

# CALIFORNIA AND WESTERN MEDICINE

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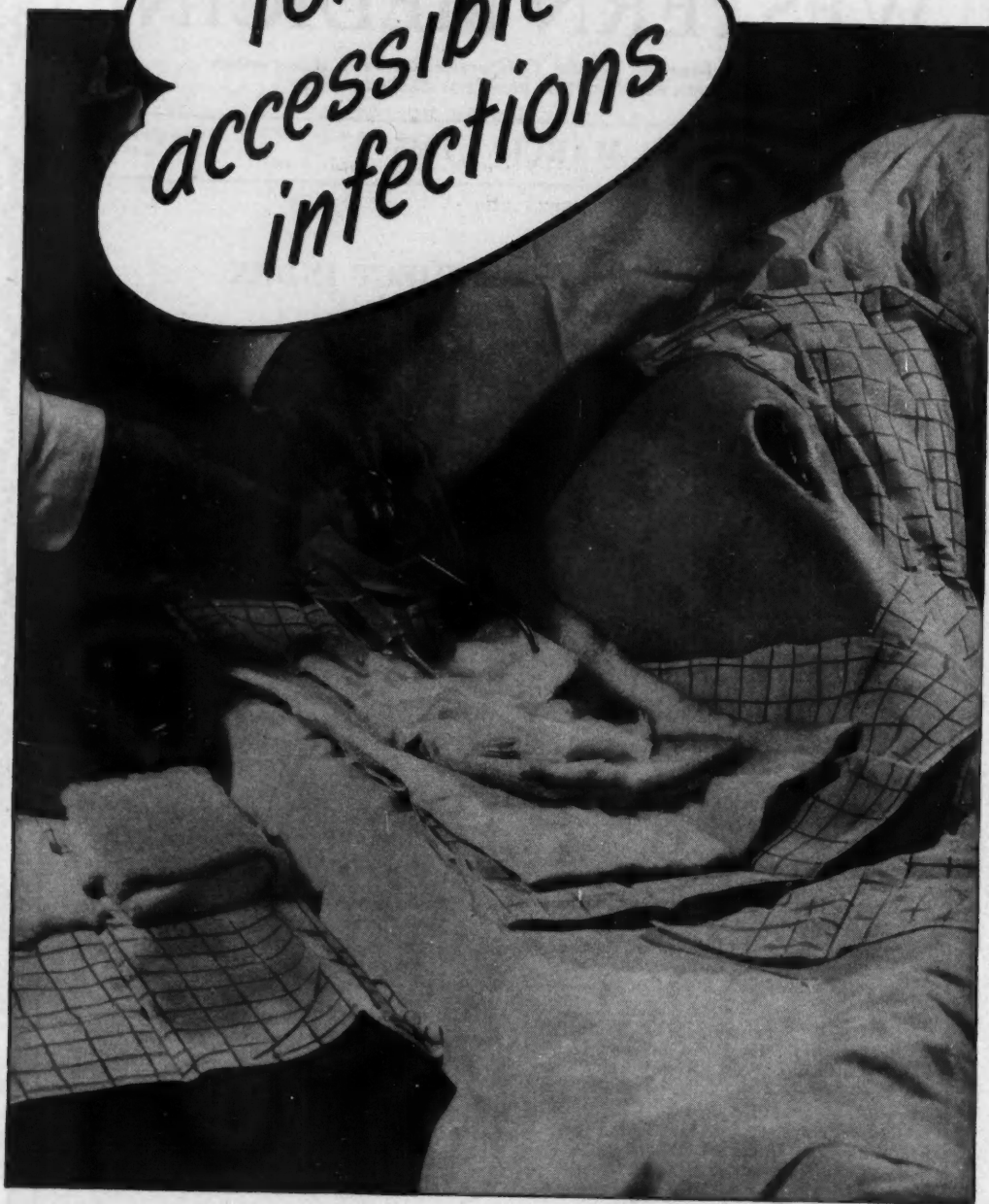
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# CALIFORNIA AND WESTERN MEDICINE

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## California and Western Medicine

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EDITOR . . . . . GEORGE H. KRESS

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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George W. Walker (Chairman) . . . . .	Fresno	1946
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**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### III. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Continued)

**Analysis of Proposed Sickness Insurance Laws.**—The Voluntary Sickness Insurance Act proposed by the California Medical Association was printed in full text in CALIFORNIA AND WESTERN MEDICINE, for February, on page 65, and an analysis of its major features appeared on page 91.

Analyses of the two compulsory measures: the C.I.O. bill (A.B. 449) and Governor Warren's proposed law (A.B. 800) were given on pages 89 and 90.

Also, some sixty items dealing with the prospective legislation appeared on pages 68-92. Those informative comments were given space so that physicians who were too busy to have the time to follow the discussions of the controversial issues as given in the newspapers could orient themselves concerning the arguments put forth by the proponents and opponents of the various bills. Similar information on later legislative and allied developments is given in this current number.

\* \* \*

**Hearings During the Recess of the Legislature.**—The 56th California Legislature recessed on January 27, to reconvene on Monday, March 5th. During the recess period the legislators returned to their homes, for presumable consultation with their constituents regarding bills that were submitted in the month of January, 1945. (A total of more than 3,385 proposed statutes were placed in the legislative hopper during January.)

The health insurance bills were referred by Speaker Lyon to the Assembly Committee on Public Health, of which Fred Kraft of San Diego is chairman, and that committee was given the task of holding hearings during the constitutional recess. Such hearings took place in San Diego, Los Angeles, Fresno, and San Francisco, time being allotted to persons who favored and those who opposed either the general plan of sickness insurance, or wished to be on record for or against special bills: A.B. 449 (C.I.O.); A.B. 800 (Governor Warren); A.B. 1200 (C.M.A.).

The newspapers played up the reports of these meetings to such extent that the reading public has had good opportunity to become aware that

compulsory sickness insurance legislation is still a highly complicated and unsettled, and therefore, a very controversial subject. It is to be hoped that the voters will sense that a final and simple solution of the problem is not available at the present time and that they will so inform their legislative representatives in Sacramento, suggesting careful study before any compulsory laws are enacted. For reference to what took place at some of the hearings above referred to, see pages 125 and 128.

\* \* \*

**Governor Warren's Error in Procedure.**—It is to be regretted that Governor Warren and his advisers did not get together to draft his measure at least six months or so ago, instead of announcing his intention to draft such a law a brief two weeks or so before the 56th California Legislature convened on January 8. Press dispatches from Sacramento dated December 29, stated: "Governor Earl Warren today announced he will submit to the California Legislature meeting next month a plan of compulsory health insurance financed by a payroll tax on both employers and employees." The Governor's message to the Legislature on "Prepaid Medical Service" was presented on January 8. His conference with members of the Council of the California Medical Association took place on December 13. (See *JANUARY CALIFORNIA AND WESTERN MEDICINE*, pages 27, 29 and 34.) Had he prepared his draft in ample time, submitting his prospective law to the constituted authorities of the California Medical Association, the reasons why the organized medical profession of California objected to laws that would lower the quality of medical care, thus to become a distinct menace to the health interests of the people, would have been given him.

Similar criticism may be made concerning the manner in which the C.I.O. bill (A.B. 449) was brought to the front.

\* \* \*

**Up to the Present the Burden of Medical Care of the Poor Has Been Largely Borne by the Medical Profession.**—Physicians through all the years have gladly given medical care to indigent and many other citizens, and that without financial compensation. Witness, for example, the services having money value of many millions of dollars, rendered each year by the staffs of physicians and surgeons of the public county hospitals of California. It follows, concerning the principle of providing adequate medical care to all citizens, Doctors of Medicine are in full accord with that objective. The record of the medical profession is clear on that point.

Some of the shouters who are demanding enactment of compulsory sickness legislation, but who, themselves, have had no such record of generous and altruistic service to their fellow men, would do well to remind themselves of this fact when they are exploiting some of their visionary and incompletely thought-out plans. As one listens or reads the mouthings of certain of

the newer social welfare propagandists, one is reminded of what Carlyle said, when at a different period he spoke of such efforts as "this universal syllabus of philanthropic twaddle," or what some modern-day commentators perhaps would call "philanthropoid will-o'-the-wisps."

Wherefore, it can be stated again that in honest and faithful devotion and application of the best principles of humanitarianism, the medical profession can be said to occupy first place.

However, while members of the medical profession may be willing to give medical care (1) to the indigent, (2) to the medically-indigent (persons with means sufficient for the three basic needs of food, clothing and housing), and even (3) to the group of wage earners immediately above the medically-indigent (those whose budgets, after they have availed themselves of accessories of American living, such as radios, electric washers and other equipment, and so on, often on time payments at the instance of high pressure salesmanship), it is not surprising that physicians hold that they should not be called on to accept compulsory sickness insurance plans that would lower the quality of medical care, not only for the above groups, but also for other citizens.

For, in the last analysis, the health needs of the above groups are associated with real or relative poverty, and the State might better concern itself with ways and means to eliminate that poverty, rather than to try to find its solution through the establishment of radical systems of compulsory sickness insurance that would only add to the misfortunes of those citizens.

\* \* \*

**Why are Sickness Insurance Plans Controversial?**—The differences of opinion concerning sickness insurance laws rest therefore, not on the laudable objective to improve the distribution and quality of medical care, but rather upon the procedures and manner whereby the proposed betterment in medical service will be brought about.

It is true that in countries such as Germany (through Bismarck in the year 1811) and in England (through Lloyd George in 1911),—after gross neglect by those governments of the health of their workers prior to those years had made it necessary for those nations to institute sickness insurance by the capitation method—the health status of their respective populations in the lower wage groups was improved somewhat. However, those experiences in environments totally different than those of America preclude their use as shining examples to be imitated by the United States.

Before the institution of the Krankenkassen of Germany and the panel system of Great Britain, the medical care given to the citizens of those countries was on a much lower scale than that given to American citizens of similar economic groups during the same periods. This fact must not be forgotten in discussions.

And through all the years following the establishment of the German and English systems, the health care of American citizens in the lower wage groups has been of a better type than that prevailing in Germany and Britain.

The lower morbidity and mortality statistics, year by year, on record for the United States bear evidence on this point.

\* \* \*

**"State or Political Medicine."**—The compulsory sickness insurance plans of Germany and Britain have produced what has been aptly called, "political medicine," a type of practice that is decidedly different from scientific medicine; as the latter is understood and practiced in our own Country under a system of free enterprise, with decent rewards for initiative and efficient service.

The proponents of the C.I.O. bill (A.B. 449) have stated that a physician operating under their capitation plan, granted he is able to obtain his full quota of such patients, would be able annually to earn about \$12,000 gross. This would mean a yearly net maximum ceiling income of about \$6,000. True, they add, the physician would have the right to secure additional patients, but with such a system in operation, this is more a theoretical than a real possibility.

\* \* \*

**The Costs of a Modern-Day Medical Education.**—A physician prepares himself for his profession through some ten to fifteen years of hard study, (high school, 4 years; college of liberal arts, 4 years; school of medicine, 4 years; internship, 1 or 2 years), securing this training during some of the best years of his life. In addition to what he might have earned in business during that period, had he decided on a commercial career, his money outlay for education may amount to some ten to fifteen thousand dollars, or more.

Under the capitation plan, what could this medical man look forward to in the years to follow, even if he catered to the number of capitation patients that would be permitted him?

From the State, for such professional services, the physician would receive a net ceiling income not in excess of \$6,000 per year, and with that amount he would be expected to maintain his station in life, purchase a home, clothe, feed, house and raise a family! Without being mercenary, the question may be put,—From what other profession or business are similar demands made?

\* \* \*

**Effects of State Systems of Medicine on Future Disciples of the Healing Art.**—After five to ten years of operation under a system of compulsory medicine, with its regimentation and political supervisors and bureaucracies, the question may be asked,—Would the profession of medicine be as attractive in the future to high-thinking, altruistic, and well educated men and women, as it is today? It is not reasonable to

think that under such conditions, our intelligent young people would aspire to become physicians in same number as at present. The educational standards of neophytes in medicine would be certain to deteriorate, and consequently, medical care of the future would be of a lower quality than at present.

\* \* \*

**Public Must be Made to Understand that "Political Medicine" is Poor "Scientific Medicine."**—In the discussions concerning the compulsory C.I.O. and Warren sickness insurance bills now pending in California, it is unfortunate that so many citizens are under the impression that the proposed medical care under either of those plans would be as good as under the prevailing methods of private practice. If citizens could realize what will happen under the C.I.O. or Warren plans, they would be less willing to support either of those measures.

\* \* \*

**First C.M.A. Conference was Held on January 25.**—The constituted authorities of the California Medical Association—the Council, Executive Committee, and Committee on Public Policy and Legislation—have taken steps to promote the objectives outlined in the resolutions adopted by the C.M.A. House of Delegates at its special session in Los Angeles, as printed in CALIFORNIA AND WESTERN MEDICINE, for January (page 32).

The first C.M.A. conference with representatives of the State Government, Management, Labor, Agriculture and Affiliated Professions was held in Sacramento on January 25 (for report thereon, see CALIFORNIA AND WESTERN MEDICINE, for February, page 85). Other conferences will follow while the Legislature is in session.

\* \* \*

**Probable Date of Adjournment of the Legislature.**—It has been stated in the press that the present session of the California Legislature will probably continue through the month of May. It is possible that Administration measures bearing on general taxation and related matters will have first attention during the month of March. Thereafter, the battle concerning the health insurance bills will again receive special notice in the newspapers.

During these intervening weeks, the education of the public, insofar as physicians themselves can take part in such work, must be vigorously carried on. There must be no let-down in the campaign. Every physician has a responsibility, and must do his part in the promotion of efforts that will maintain a high quality of medical care, to the end that the best health interests of California citizens may be protected.

\* \* \*

**C.M.A. Members Will be Kept Informed.**—Members of the California Medical Association,

through bulletins and other announcements, will be kept in touch with the activities of their state and county society officers. It is hoped, when a call for special action is received by a C.M.A. member, that the response in efficient cooperation and service will be promptly forthcoming.

Some excerpts from the resolutions adopted at the special session of the C.M.A. House of Delegates in January last, may be restated for readers:

*"Resolved, That recent proposals to establish some form of compulsory health insurance in this State have come at the last minute without any opportunity for adequate consideration and planning by any of the many interested groups, or sufficient time for interchange of opinions and knowledge. . . ."*

*"Resolved, That the California Medical Association is of the firm conviction that no fundamental and revolutionary change in the practice of medicine should be made under present wartime conditions. If disruption occurs in the rendering of medical service, the result can well be a catastrophe for the people of the State. . . ."*

*"Resolved, That the California Medical Association cannot endorse any system of compulsory health insurance which has thus far come to its attention. . . ."*

\* \* \*

**A Defective Sickness Insurance Law Would Be a Real Calamity.**—To be kept in mind is the important fact that a defective sickness insurance law will aggravate whatever deficiencies in medical service may now exist. To inflict such a defective law upon the people of California would be unpardonable.

A careful study of existing needs by a properly implemented State Commission would seem to be in order, before California embarks upon a compulsory sickness insurance plan such as would come into operation if either the C.I.O. (A.B. 449) bill or Governor Warren's measure (A.B. 800), were enacted by the Legislature.

\* \* \*

**C.M.A. Bill (A.B. 1200) Offers a Solution.**—If the proponents of immediate action in sickness insurance are in earnest about giving better medical care to certain wage groups, a proper beginning may be made through the enactment into law of the bill submitted by the California Medical Association (A.B. 1200).

The old slogan, "Stop, Look and Listen" should be taken to heart by those who advocate the enactment of compulsory sickness insurance laws that contain implications dangerous to the best interests of the public health.

Otherwise, if they should by chance succeed in their endeavors, they and the other citizens of California may long live to rue their undue haste with which they brought about the enactment into law of their immature, poorly conceived and impractical plans.

#### C.M.A. MEETING OF MAY 6-7, 1945

**Session to be Held in Los Angeles—Will be a Local Meeting.**—The Office of Defense Transportation does not give approval to meet-

ings necessitating public carrier travel by more than 50 persons.

When the C.M.A. House of Delegates meets in Los Angeles on Sunday-Monday, May 6-7, 1945, the number of official delegates using public carriers from northern and other county medical societies will be held down to less than 50, as stated in *CALIFORNIA AND WESTERN MEDICINE* for February, on page 97.

The meetings of scientific sections will be practically local in character; that is, attendance and participation will be largely by members of the Los Angeles and contiguous county medical societies, who can use their own automobile transportation in travel, returning to their homes on each of the two evenings, in that manner doing away with the use of hotel accommodations. Papers will be read "by title" (the essayist not being required to be in attendance), or through agreement, by some member of the Los Angeles or other nearby county society as noted in the *CALIFORNIA AND WESTERN MEDICINE* item referred to above.

For the information of C.M.A. members who may look with suspicion upon a meeting under auspices as here outlined, as being too small in scope, it may be in order to call attention to the fact that only ten state medical societies have a larger membership than the Los Angeles County Medical Association. The number of members credited to the ten state associations of larger size, as listed in the *J.A.M.A.* of April 29, 1944, include: New York, 18,908; Pennsylvania, 9,951; Illinois, 8,623; (California, 7,550); Ohio, 6,752; Massachusetts, 5,528; Texas, 4,607; Michigan, 4,567; New Jersey, 4,294; Indiana, 3,397; and Missouri, 3,252.

The above figures are given to remind Los Angeles County and other members that, even though this year's session of the C.M.A. will be "local," it should be possible to have adequate attendance at the meetings of scientific sections, without conflicting with the rules of the Office of Defense Transportation.

In this, as at last year's session, there will be no scientific or commercial exhibits. Nor will there be any dinners or social events.

Meetings will be held, not in hotels, but in the Elks Temple lodge rooms and the headquarters of the Los Angeles County Medical Association.

The publicity regarding the scientific programs will be largely carried on through the Los Angeles County Medical Association.

All papers, whether read by title or otherwise, will be eligible for consideration and possible publication in *CALIFORNIA AND WESTERN MEDICINE*, thus insuring up-to-date articles for readers of the *OFFICIAL JOURNAL*.

Members in and about Los Angeles who can attend under the conditions noted above, should make note of the days and arrange to be present.

In due course, additional notices pertaining to the meeting will appear.\*

\* See also item on page 137.

## EDITORIAL COMMENT†

## MILK-BORNE CARCINOGEN

For a number of years the staff members of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, have made genetic studies of spontaneous tumors in several intensively inbred strains of mice. Under natural methods of propagation, these strains showed widely different hereditary tendencies to the development of spontaneous breast tumors. At one end of the scale there were certain families, 95 per cent of whose members eventually died of mammary carcinoma. At the other extreme there were families in which the incidence of spontaneous breast tumor was as low as 0.5 per cent.

About 10 years ago<sup>1</sup> the natural method of propagation was purposefully or inadvertently altered, many of the young being reared by foster mothers. It was then noted that the fostered young tended to acquire the carcinogenic percentage of the foster parents. Thus, a 94.7 per cent susceptible strain was changed to a 0.7 per cent strain as a result of refractory (0.5 per cent) foster-feeding. A 0.5 per cent (refractory) strain became highly susceptible (89.8 per cent) as a result of 95 per cent susceptible foster-feeding.

Seven years study of foster feeding<sup>2</sup> has shown that foster modification of hereditary percentage is not due to a protective antibody in non-carcinogenic milk. It is apparently due to a deleterious "influence" in carcinogenic milk. This pathogenic "influence" is present in the milk of carcinoma susceptible mice during the entire lactation period, and is afterward demonstrable in aqueous extracts of the tissues of the fostered young. Adequate confirmation of these findings has been reported by other investigators.<sup>3</sup> Law<sup>4</sup> and Cloudman,<sup>5</sup> for example, found that the milk-borne carcinogenic "influence" also increases susceptibility to experimental inoculation with mouse leukemic cells.

Attempts to determine the nature of this milk-borne "influence" have been made mainly by a study of the same "influence" in extracts of lyophilized breast cancer. In his initial experiments Bittner<sup>6</sup> fed 10 young mice of a cancer resistant stock with 2 cc. of this carcinoma extract. Six of these mice developed spontaneous breast cancer by the end of 12 to 14 months. None of the brother or sister controls not given cancer filtrate developed breast tumor. It has been shown that the active principle in such carcinoma extracts can be partially sedimented in the ultracentrifuge (20,000 to 110,000 times gravity).<sup>7</sup>

Attempts to determine the chemical properties

of this pathogenic agent are currently reported by Barnum<sup>8</sup> and his associates of the Division of Physiological Chemistry, University of Minnesota. Some of the reported chemical properties of this agent are of suggestive clinical interest. This is particularly true of their studies of its thermostability. In a typical experiment breast tumor tissues were homogenized with distilled water, and the resulting supernatant fluid divided into 5 aliquot parts. These were kept at 4°C., 24°C., 37°C., 60°C. and 90°C. for one hour. All portions were then brought to room temperature and an amount equivalent to 1 gram of original tissue was injected into young mice.

Of the 18 mice injected with the fraction stored at refrigerator temperature (4°C.) 9 mice (50 per cent) died of spontaneous mammary carcinoma on or before the 16th month. None of the non-injected controls developed tumors. About half of the carcinogenic titer was lost in the fraction stored for one hour at incubator temperature (37°C.). The extract was completely inactivated at temperatures of 60°C. or higher. The thermostability of the carcinogenic agent is therefore approximately the same as that of serum complement. This is of possible hygienic interest since it suggests that the milk-borne carcinogenic agent would be completely inactivated by ordinary methods of Pasteurization.

At least three plausible theories have been suggested (or are implied) in the reports of various investigators. First, the observed facts could be fully accounted for on the assumption that we are here dealing with a milk-borne carcinogenic virus. Thus far, the virus theory has not been adequately tested. The observed facts could also be accounted for on the assumption that we are here dealing with a milk-borne hereditary gene or its equivalent. This futuristic theory also has not yet been supported by adequate experimental evidence. Finally, the observed facts could be accounted for on the assumption that the milk factor is an organ-specific cytotoxin causing sufficient permanent injury to homologous tissue cells of the fostered young as to completely destroy its hereditary cancer resistance in late adult life. This theory finds some support in Law's<sup>9</sup> recent discovery that in certain inbred mouse strains, repeated injection of certain bile derivatives during infancy leads to a significant increase in the incidence of spontaneous carcinoma in later life.

These and other more complex plausibilities are now under investigation.

P. O. Box 51.

W. H. MANWARING,  
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

# ORIGINAL ARTICLES

## Scientific and General

### COMPULSORY HEALTH INSURANCE\*

RADIO BROADCAST ON LAWS SUBMITTED TO  
CALIFORNIA LEGISLATURE

STANLEY K. COCHEMS  
Los Angeles

**F**ELLOW Citizens of California: Governor Warren in addressing you Wednesday evening made a passionate plea for the immediate institution of prepaid health insurance in this State, in support of Assembly Bill No. 800, now before the Legislature. However, the Governor did not call his plan a compulsory plan until near the end of his address.

I will deal only with facts—facts important to you and to me, as citizens and taxpayers.

We will consider the two compulsory health insurance bills—the C.I.O. Assembly Bill No. 449, and Governor Warren's Assembly Bill No. 800. In essence these bills are very similar. The Governor and the C.I.O., through statements publicly made, are attempting to sell futures in a service which they do not own or control; and a service which now and for years to come cannot be delivered.

A false impression is current that compulsory health insurance means *free* medical care. That is not true. Any compulsory insurance costing taxpayers of California a minimum of \$260,000,000 a year is not free. Proposed legislation, as widespread in its effect upon all people of this State and carrying with it a tremendous menace to this State's industrial and business position in competition with other states, must have the careful consideration of *every* citizen.

Men trained in tax matters—who are experts in the problems of business and industry—have studied the Governor Warren-C.I.O. Bills dispassionately and have termed these proposals "*outrageously impractical*," and have amplified that statement by saying, that should either of these bills become law, California could not compete industrially with other states because of the tremendous handicap of added taxation.

Governor Warren, in an attempt to refute the statement that his proposal was hastily drawn, said that the question of compulsory health insurance had been considered in California for the past thirty years. That is true. But most of the studying and theorizing was done prior to 1918, and in 1918 the people of California voted 3 to 1 against a compulsory health insurance plan similar to the plans now proposed.

\* Radio script submitted by Stanley K. Cochems, Executive Secretary of the Los Angeles County Medical Association, for presentation over Statewide Blue network on Friday evening, February 23, 1945, at 9:45 P.M.

And little was done since 1918 except theorizing, until the California Medical Association decided to do something practical about it—decided to put into practice a voluntary prepaid medical service plan, following the age-old concept that the proof of the pudding is in the eating.

The California Medical Association plan, known as California Physicians' Service, has gathered the greatest amount of *factual* data relating to prepaid health insurance that has ever been gathered in *practice* in this country.

Thirty years of theorizing on the part of those who would create a Utopia by law, produced nothing but more theories. And now the C.I.O. and Governor Warren believe these theories should be tried—at enormous cost to us. They have been tried for sixty years in Germany with a result that you and I as citizens and taxpayers certainly do not want.

And now, to specific facts to prove how impractical these proposals are:

C.I.O. leaders have stated that it would cost \$250,000,000 a year, plus administrative overhead, to be borne by the State out of general funds, to give to the 6,500,000 citizens, who are now beneficiaries under the unemployment insurance fund, an adequate type of medical care and hospitalization. In that estimate the C.I.O. leaders are quite correct. It would cost that much *at least* according to experience *gained in practice* by the California Physicians' Service, which has shown that a minimum of \$40 per person per year is the cost—a total cost of \$260,000,000 a year for 6,500,000 people.

The Governor Warren-C.I.O. Bills would raise money for this purpose by a 1½ per cent payroll tax to be paid by the employee and 1½ per cent by the employer, a total of 3 per cent. In the peak year of employment, 1944, that tax would have raised only \$160,000,000. Immediately there appears inevitable a deficit *each year* of \$100,000,000 which the State would be pledged to pay out of its general fund.

Senator Pepper, in his sub-committee's report to the United States Senate, showed that the cost of completely adequate medical and hospital service for a family of three for a year would be \$241.00 or \$80.00 per person. Senator Pepper is an ardent advocate of some plan to better spread medical care. Certainly Senator Pepper would not exaggerate the cost.

If we use Senator Pepper's estimate, the cost of providing such complete care to 6,500,000 Californians would be \$520,000,000 a year. On that basis with only \$160,000,000 raised by compulsory health insurance taxes, as proposed by the C.I.O. and the Governor's Bills, there would be a deficit of \$360,000,000 *a year* which the State would have to meet with additional taxes.

Governor Warren is evading the issue in not discussing the very important financial aspects of these bills. If the State has to meet a minimum deficit of \$100,000,000—and this might become a

deficit of \$360,000,000—if we accept Senator Pepper's figures—then our legislators, in all fairness to you and to me, must tell us before they pass such legislation, how they intend to raise such vast sums in addition to the money raised by the 3 per cent payroll tax.

There are three ways this deficit could be met, and you and I should have some voice in the method of raising it. The three methods are by doubling or possibly trebling the present sales tax; or by a heavy property tax on every home, farm and business; or by creation of drastic new and heavy taxes on every form of business enterprise in California.

So much for facts relative to the financial aspects.

Now for facts to prove how impractical these proposals are:

The medical services the Governor and the C.I.O. promise to deliver to the people for a price of hundreds of millions of dollars a year are *not available* now and will *not be available* for many years to come.

Before the war, California had 9,000 Doctors of Medicine in active practice—one doctor for 800 people, the national average. The war has taken one-third of these Doctors of Medicine. The population of this State has advanced from 7,000,000 to nearly 9,000,000. Today there is one doctor to each 1,500 people.

The shortage of medical men in the United States will remain serious for many years. Young men who had planned medical careers had their plans disrupted when called to military duty. Many of these young men will not consider preparing for the practice of medicine, if they are faced with the prospect of regimentation when they are graduated.

Every Doctor of Medicine in California is exceedingly busy today. If some of our people are unable to obtain adequate medical care, the chief reason is—there are not enough doctors. And remember, this situation will not be relieved when the war ends. For each doctor who returns there will be hundreds of men returning, swelling the population of California.

The promises of adequate medical service being made by the Governor and the C.I.O., under a system of compulsion, means that our doctors would be called upon to render from three to four times the amount of service they are now delivering. Today they are delivering to the utmost of their ability. The service that is promised is a physical impossibility and could only be approached if the doctors sharply reduced the service rendered to each patient,—and that means the service rendered to you and to me,—which has been the experience of compulsory health insurance plans in Europe.

Under normal conditions of private medical practice among people who are able to pay a physician for his services, the incidence of such de-

mand for a doctor's services amounts to approximately 650 cases per year per 1,000 adults. From the practical experience gained by voluntary health insurance in California under the offering of full medical coverage, the demand immediately jumped to 1,300 cases per year per 1,000 people. In other words, the demand doubles when full insurance coverage is given, primarily because it is a human trait to attempt to get value received for the money expended, whether the thing received is essential or not.

And when children are added to the adult group under full insurance coverage, the figure jumps to 1,790 cases per year per 1,000 people. These are facts, not theories!

This constitutes a demand—not necessarily a need—for services which could not be met by the number of doctors now in the State or the number of doctors who can be trained within the next decade or two.

The Governor and the C.I.O. are promising—for hundreds of millions of dollars of your money—something that the Governor and the C.I.O. cannot deliver.

Much has been said of the demand for prepaid medical care. It is true that some practical method must be found and *will be found* to improve the distribution of medical care through practical experience being gained by voluntary plans now in existence and practical methods are being found. The problem cannot be answered by theory; it cannot be solved through "outrageously impractical" proposals.

The demand is not entirely or in any great degree for a *compulsory* program. A large percentage of the demand, as shown in a recent survey, is for some form of voluntary prepaid medical service.

Need and demand are different things. The Governor and the C.I.O. have made much of the so-called five million 4-Fs. For 30 years England has had compulsory health insurance. Experience in England has shown that 50 per cent—instead of our figure of 38 per cent—were rejected for physical and mental reasons. Physical standards demanded by the British were much lower than ours.

Senator Pepper's report to the United States Senate on January 5, 1945, presented factual data as to why men were rejected. There were 4,217,000 4-Fs. Reviewing the causes of rejection we can find no basis for believing that had a system of compulsory health insurance existed in this country before the war, this number could have been reduced appreciably.

The Governor and the C.I.O. make much of their appeal to increase the health standards of California. Our health standards today are higher than those of England and of Germany where compulsory health insurance has existed for years.

The health of the people of this State can be improved through a program of education,

through an improvement of living conditions, through teaching our people to understand the benefits, and then to make use of the many free medical services now rendered by our health departments in the control of contagious and avoidable disease.

The Governor declares that the voluntary approach has failed; that only 100,000 are insured by California Physicians' Service. The Governor failed to state, however, that other voluntary and group medical services are in existence in this State, and according to the report of the State Chamber of Commerce, 1,500,000 California citizens are now covered by this type of health insurance.

The voluntary approach is not a failure and subscribers to voluntary plans are growing rapidly in number.

Our thousands of young men in military service—our 3,000 California doctors in military service—should have a voice in the decision of these drastic proposals, which by no stretch of an active imagination can be considered emergency measures at this time. Study of prepaid health insurance in practice, not more theorizing, is needed before plunging California into a morass of debt.

Assembly Bill 1200, introduced by the California Medical Association, provides for no taxation, but would greatly encourage the growth of voluntary, prepaid medical service plans.

1925 Wilshire Boulevard.

## DIAGNOSIS OF INDUSTRIAL POISONING\*

ALICE HAMILTON, M. D.  
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**A** RULE for the diagnosis of industrial disease was laid down way back in the seventeenth century, by Ramazzini, the first great student of occupational disease. He bade the physicians in Italy, when they had a case of illness in a working man, not to ask him only about his symptoms but to go carefully into all the details of his occupation; for without this knowledge, they would not be able to make a correct diagnosis. It cannot be denied that Ramazzini's advice is still needed, at least by medical students and hospital internes, for most medical schools still leave out industrial medicine from the curriculum and students graduate with more information about amoebic dysentery than about lead poisoning. And, as one who has had to go through many hospital records, I can assure you that the average interne has little intelligent interest in the history of the patient's work. Often he is content with the word "laborer," which tells us only that the man belongs to what our radicals call the "proletariat." Or, perhaps he goes so far

as to write "lead worker," but that tells us far too little. We do not know how great the lead exposure was, nor how long it lasted, and those facts have an important bearing on the diagnosis. Mixing white lead paint in an open chaser may bring on a form of plumbism which would never occur in a man who handled freshly made lead grids for storage batteries. The slow accumulation of lead in the body gives rise to one clinical picture, the sudden flooding of the body with soluble lead, to quite a different one.

I remember a case which came before a compensation board with a claim for arteriosclerosis caused by lead and resulting in cerebral hemorrhage. The history showed that the young man had been employed for only six months in a lead foundry, handling metallic lead. Such a profound effect could not take place in so short a time and from so slight an exposure. On the other hand, an acute attack of maniacal excitement in a man who spent three days cleaning out the separator in a white lead works, should be accepted without question.

It is, however, not enough to know what the patient's job was: one must discover whether there was any poisonous substance in his immediate vicinity, for it is not safe to assume that because his job is safe, he is not exposed to poison. For instance, I was much puzzled by a case which seemed clearly one of lead poisoning, in a man working in a rubber plant where lead was added to the rubber in the mixing mills. He assured me that he worked only at a mill compounding leadless rubber, but a visit to the plant showed that in two of the nearby mills, lead was mixed with the crude rubber. Neither of those men was leaded, but the man working near by was. It was just one of those cases of oversusceptibility which we cannot explain.

On the other hand, it is not safe to assume that because a man is employed in a chemical works where poisons are produced or used, his sickness is occupational in character, for close inquiry may show that he is in the department making containers and never comes in contact with the chemicals. Often it is very difficult to discover just what the man's exposure has been. I remember a case of aniline poisoning during the first world war, when we in this country had to begin the production of aniline because the German supply was cut off. There was much chronic anilinism in those days, and in Akron the victims were called "blue boys," because they were deeply cyanosed and dyspnoeic, like men with cardiac decompensation. It was in the compounding and mixing rooms of the rubber plants that the aniline was used, and my man worked only in the heat vulcanizing department, yet he had a typical case. Finally a rubber chemist cleared it up by telling me that the heat of vulcanization resulted in the production of aniline-like bodies, which escaped when the vulcanizers were emptied.

Even when the manufacturer tells you frankly the composition of the solvent or thinner he is

\* Guest Speaker's Address. Alice Hamilton, M. D., is Professor Emeritus of Industrial Medicine, Harvard University Medical School. Given before the Third General Meeting at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

using, or the welding rod or flux, the information may be misleading, for the purveyor of these may suddenly change the formula, as prices change, and not notify the users of the change. Thus cases of coal tar benzol come to light in establishments where only toluol or petroleum naphtha is supposedly being used. The new process of producing gasoline, by cracking, distillation at great heat, results in the formation of aromatic compounds, benzol, toluol, etc., so that the final product is not only gasoline, but gasoline-benzol, capable of producing the typical symptoms of benzol poisoning.

The second thing I wish to emphasize is the over-narrow rules we have adopted for the diagnosis of occupational poisoning. Under the influence of the compensation laws and the insurance companies, we have become too cautious. If we are dealing with an industrial case, we feel we must be absolutely sure that it conforms to the type of poisoning as given in the text books, those books with which we shall be confronted when we go before a compensation board. We feel we must be ready to defend our diagnosis with reference to the authorities and this leads us to accept a picture of an industrial intoxication which is correct, of course, but is not the only correct picture. In non-industrial diseases there are no such strict standards. Take those blood dyscrasias, Schultz' agranulocytic angina, and the various forms caused by the action of radio-active substances. Any variety of blood abnormality is accepted, no matter how it differs from that originally described. But not so, if the disease is of occupational origin.

When we were studying those distressing cases of radium poisoning in dial painters in New Jersey, the lawyers were insistent that we give them a definition of radium poisoning, so that they could go into court properly prepared for every contingency. We refused, of course, we knew that cases unrecognized at that time, would appear later on and we would have to keep widening the definition. And of course that happened, the slower cases developed osteo-sarcoma, but only after a long interval. As to benzol poisoning, I came across the discussion of a case which came before Richard Cabot's clinic, a man exposed to benzol, dying of either hemorrhage or septicemia, I do not remember which, but because the autopsy revealed a hyperplastic bone marrow, instead of the classical aplastic form, the diagnosis of benzol poisoning was rejected. I was called in on a compensation case in which benzol exposure was admitted, but the blood picture was not typical, there were regenerative and abnormal forms of red blood corpuscles, and so it was declared to be a case of pernicious anemia.

Now we have progressed beyond that rigid limitation, we can nowadays insist that benzol poisoning may result in any one of many blood changes, in accordance with the part of the bone marrow that sustains the severest attack. There

may be anemia, or polycythemia; leucopenia or leucocytosis; complete aplasia or signs of regeneration. There may even be typical leukemia, of the myelogenous or the lymphatic type, no less than twelve cases are now on record and nobody can guess how many more might be had had not physicians been held back by too rigid ideas. The latest extensive study of benzol poisoning, made by groups in Boston and New York, resulted in the conclusion that in men a hyperplastic marrow is more usual than an aplastic, in women the latter is the rule. It is even suggested that our belief in the over-susceptibility of women to benzol may be founded on the rejection of cases of hyperplasia and acceptance only of those with aplasia, whereby most of the male cases have failed to be recorded. How many cases have been lost because a septic process dominated the picture, it is impossible to guess, but the diagnosis of Vincent's angina or septicemia has certainly covered many cases of benzol poisoning, for the disappearance of the protective substances from the blood has been repeatedly shown to be part of the action of this solvent.

The anoxemia of carbon monoxide may result in death of those cells which cannot stand the lack of oxygen. Most of the body cells, when destroyed can be regenerated but not the cells in the gray matter of the central nervous system and the basal ganglia. Moreover, although the cells in the walls of the smaller blood vessels may later be regenerated, for a time there is a weakened vessel wall and there may be a hemorrhage which, even from the smallest vessel, has serious consequences because it occurs in an important region, such as the gray matter of the brain. Such cases, that follow an acute gassing, are, I think, the most puzzling that come to us as industrial toxicologists. Several cases of atrophy of the optic nerve following a not too severe gassing have come to my attention. I felt I could not be positive on the first case I saw, but only a few years later I came across two such cases in the literature. As they were not industrial, they had attracted little attention, but they were just like the case I had rejected, the gassing had not been severe, but the effect upon the optic nerve had been very severe.

Another puzzling case was one of fatal hemorrhage in the course of typhoid fever. The man had been severely gassed a month before he came down with typhoid fever. He was progressing fairly well and had every prospect for recovery and then suddenly he had a fatal hemorrhage. The claim on behalf of the widow was that the gassing had weakened a vessel wall and caused the hemorrhage. This may have been true, I do not know, but no compensation board would accept an explanation like that as being anything but hypothetical.

A similar case of cerebral hemorrhage occurred in a worker in a steel mill in South Chicago, two or three months after a severe gassing. Something happened to raise his blood pressure sud-

denly and the man had a hemorrhage, but not fatal. His claim for compensation, of course, was also turned down. There may be all kinds of sequelae, depending on the site of the pathological changes which may be caused by the anoxemia of carbon monoxide poisoning, when the gassing has been prolonged and severe.

As for lead poisoning, there are still forms of it that puzzle us even after all the years of study of this occupational disease. For instance, there are cases in which the symptoms involving the joints, hardly ever the muscles, dominate the picture and obscure the diagnosis. That remarkable pioneer in this field, Tanguerel des Planches, who described a hundred years ago various forms of plumbism, warned the physician that he might see cases of what seemed to be rheumatism, with none of the ordinary symptoms of plumbism, yet of plumbic origin.

Carbon tetrachloride poisoning is not typically slow, gradual, chronic in its course. The typical history is one of a heavy exposure, resulting in an attack of nausea, headache and a little later a dark colored urine and some time after that evident jaundice, that is typical. The pharmacologists have done a great deal of work on carbon tetrachloride because of its use in the treatment of hookworm infestation. Their publications show that in animal experiments the lesions in the liver are the most conspicuous, but do not be misled by animal experiments. In human beings the symptoms that are referable to the kidneys are the most marked, in severe cases death usually comes from uremic poisoning. There are also cases of marked nervous disturbance, convulsive seizures, even neuropsychoses following an acute narcosis from carbon tetrachloride fumes. Even progressive muscular atrophy has been described. Two cases have come to autopsy which showed typical sclerosis of the liver.

It is important to remember that trade poisonings have not been confined to the trades. This danger penetrates into the home in many cases, from ignorant use of dangerous substances which are sold in an unlabeled can or a can labeled with utterly undescriptive labels. One of the Public Health Service men told me that he thought he had found 35 different names for carbon tetrachloride to be used in the home for dry cleaning, for painting, and still worse for paint removal, for treating floors and for removing shellac. All of these carry with them the danger of the same kind of poisoning that occurs in industry so it is not only the industrial physician that must bear the possibility in mind.

In closing I wish to emphasize the importance of reporting all cases of industrial poisoning. I know there is a tendency to report only those cases that are unusually interesting, but it is only by having all the manifestations revealed that we shall ever get a true picture of a poison. Why is it we say such and such a poison never causes such and such a condition? It is because so far

it has not been reported and it may not have been recorded because the man who saw that unusual case is very busy and he has not written it up. Some of you see many cases of occupational disease and it is really your duty to give those cases publicity, especially if there is anything unusual about them. If you think an industrial poison had anything to do with a certain case of illness, put it on record, because your contribution will help to make up the general picture which at present is certainly incomplete, even with regard to the most familiar of the poisons.

Now I believe we are to go over to the panel discussion:

DR. HAMILTON: My two questions will not take very long. The first is the effect of industrial poisoning on early pregnancies. An industrial poison may produce hemorrhage and cause abortion in that way. Benzol is the most striking instance of that. An industrial poison may enter the fetal blood through the mother's blood and result in death of the fetus. The most striking instance there is lead. There are very interesting statistics about lead from the older countries where women were long employed in dangerous lead trades whereas they have never been here. Lead is a poison to the germ cell and a leaded woman is likely to be sterile, if she conceives she is likely to miscarry, if the child is carried to term, it is likely to be born dead and, if it is born living, it is likely to succumb within the first year of life. A very interesting study in Japan showed that paternal lead poisoning, which has often been shown in animals, is also evident in human beings, for they were able to compare the marital histories of two groups of Japanese workers in a great storage battery plant, those working with the lead and those not coming in contact with the lead. They found a greater degree of sterility in the wives of the lead workers compared with the wives of those who were non-lead workers. Lead has been found in the blood of the fetus.

Carbon monoxide was used as an abortifacient in Roman times. Even when it did not seem to affect the mother severely, it did affect the fetus. Any poison which enters the circulation of the pregnant woman is very likely to have some effect on the fetus. I am giving you only the facts I know, but you can see there must be other poisons which would have an indirect effect on pregnancy. Certainly any condition that would cause convulsions might result in expulsion of the fetus.

(2) What are the early signs of carbon tetrachloride poisoning? These are symptoms of a narcotic poison, increasing headache, dizziness and confusion, simply what occurs in the early stages of any form of narcotic poisoning. If it goes on day after day there may be a gradual loss of health which will not be at all characteristic. There is nothing that is characteristic of the early stages of carbon tetrachloride poisoning. The symptoms are just like those caused by any one of the narcotic group.

Hadlyme, Conn.

# LIMITATIONS OF OBJECTIVES IN PSYCHOTHERAPY\*

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*San Francisco*

THE future historian of medicine will describe the beginning and the middle of the 20th century as characterized, on one hand, by the greater recognition and understanding of the neuroses and, on the other hand, by the development of a rational psychotherapy of the neuroses. Progress in treatment usually takes place with adequate crystallization of the various disease entities, so that the special problems in each condition can be attacked. There is little doubt that the greatest understanding of the neuroses has come to us through the teachings of Freud and his students. To be sure, there were many contemporaries of Freud who had approached the problem of neuroses in the same manner, and who held many of the ideas which Freud expressed at the same time. In this country, certainly, Adolf Meyer developed quite independently an approach to the psychoses, which paralleled in many respects Freud's ideas about the neuroses. We all know that scientific discoveries are seldom arrived at by one person. There are usually several investigators who simultaneously come upon the same idea, as was the case with the discovery of the principles of heredity, the discovery of insulin in the treatment of diabetes, liver in the treatment of pernicious anemia, etc. Freud's genius consisted largely in the fact that he did not try to approach the problem of the neuroses from the point of view of structural anatomy, which in his time was the only scientific approach to the progress of medicine. Freud observed, quite correctly, that in the neuroses one does not have a disturbance of any one organ, but that the whole organism is disturbed, and the disturbance is characterized by the difficulties in articulation of the individual to his immediate social group. He was also keen enough to observe that the organism is never the same, that its reaction changes constantly, hence he felt that the human organism should not be studied from the point of view of structure, but as an ever-changing body, i.e., a body in motion. Freud then proceeded to apply the technique of physics rather than anatomy to the study of nervous disturbances in human beings. This is what really constitutes the so-called dynamic approach about which we at present speak so much. The earliest writings of Freud contain terms of the physics of his day, such as vector, polarities, valences, quantities of libido, etc.

Freud's therapeutic ambitions were modest. He felt that with proper understanding of the drives of the individual, and of the repressions and frustrations which curbed these drives, and

by the employment of the special technique of unraveling conflicts, one could clear up a certain amount of amnesia which accounted for so much unmotivated and frightening behavior. By means of such therapy Freud felt the patient was bound to become better, especially if the therapist was aware of the fact that he was serving as a lightning rod upon whom the patient could discharge many of his childish, immature emotions. Freud was frequently skeptical about the therapeutic efficacy of analysis and was more proud of it as a research tool than as a system of psychotherapy. There was good reason for his modesty in the field of therapeutic ambitions. As a young man he had seen some spectacular and brilliant results by some of the best psychotherapists in the world, such as Charcot and Bernheim. He realized full well that he could not possibly match his results with theirs. Freud again demonstrated his genius by the fact that he was rather unimpressed by the spectacular therapy that he saw. He, being primarily an investigator, wanted to learn what caused the puzzling conditions that he saw constantly in the big Vienna clinics and in his own private practice. The followers of Freud, operating and experimenting with psychoanalysis, found that they had at their hands a very powerful tool, which not only cleared up symptoms but frequently affected profound changes in the personality of the patients. As a result of psychoanalysis one occasionally saw a complete change in patients; some of them seemed to be new, re-born people. Patients suddenly found themselves in possession of great stores of energy which they now could use freely and effectively, so that they became different persons. The psychotherapist who mastered psychoanalysis became ambitious to produce such changes rather than to relieve symptoms in patients who came for treatment. The whole practice of psychotherapy and psychoanalysis is changing. For the past few years, patients who have come to psychoanalysis have not come for treatment of symptoms, but for changes in character so that they might become more capable, more efficient, more fully developed, more mature human beings. As Helena Deutsch puts it, the character of neuroses to be treated has changed. It is no longer the severity or mildness of the symptoms which is important, but the so-called residual personality. Psychotherapists are speaking constantly of deep therapy, implying that it is the only therapy worth mentioning. In presentation of case material, one constantly hears apologies for "superficial" treatment of the case and the lack of a "deep approach." Competent psychotherapists apologize for the excellent results because they are not able to offer elaborate explanations of why the patient improves. There seems to be an impression that the improvement in the patient, unless it is obtained through psychoanalysis, is temporary, and that the patient is doomed unless he has the benefit of analysis. At the same time the situation in the country as a whole has changed a great deal in the past 25 years. We

\*Chairman's Address. Read before the Section on Neuropsychiatry, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

From the Department of Psychiatry, Mt. Zion Hospital.

have never had in this country the tremendous hostility to analysis which was the fate of analysis in Europe. There, quite rightly, the psychoanalysts felt scorned, rejected, humiliated, and most of them isolated. Many became extremely sensitive, suspicious and mistrustful of medical men. Unfortunately, this attitude persisted after their arrival in this country. In America now, the general practitioner, the internist, the gynecologist, the pediatrician, are aware of the existence of neuroses in patients, they recognize them, and they are perfectly willing to refer patients to the psychiatrist for treatment. The referring physician cares very little what technique the psychiatrist is using as long as his patient gets better. There is no real rift between psychiatry and psychoanalysis. In connection with the war, there has been a tremendous education of doctors in the fundamentals of psychiatry through the medium of the Army and Navy. The large number of physicians in the Armed Forces are learning to recognize the neuroses in their patients, and are anxious for the help of a psychiatrist. Not being handicapped by fear of competition, doctors in the Army and Navy are able to practice the finest medicine possible.

Consultations are frequently sought and exchanged, and a psychiatric point of view is appreciated by the military. Upon discharge of a large number of men from the Armed Forces on account of neurotic disabilities, a large group of men will appear in the community who will be aware of the need for psychiatric care and who will undoubtedly seek it. With such a terrific pressure in this crisis the well-trained psychiatrist must justify his existence by helping as many people as he can, even though it is more lucrative and in some respects more interesting to restrict himself to the field of psychoanalysis. I must say, since the problem began to be appreciated even before the war, there have been attempts to treat several patients at a time by means of group therapy. Thus far, it has been most successful in the treatment of children and institutional cases. In the field of individual therapy, there has been a great increase of psychiatric clinics throughout the country, and the leading psychoanalysts have attempted to solve the problem by organizing special clinics where patients could be treated by psychiatrists who have psychoanalytic orientation or insight, that is, persons who are specially trained in the understanding of the dynamics of therapy.

In relation to the war, we are forced to examine our goals. Are we attempting to change people, or is it our job to cure symptoms and to secure a better adjustment of the patient to his family, his friends, and to his work? Should we become imbued with a lofty ideal to reconstruct and change people, assuming that we have the capacity to do so? We then have to deal with the questions of ultimate values; almost a philosophical or theological problem. If we look upon psychiatry as a part of medicine, then our aims

and ambitions are much clearer. The aim of therapy in medicine is to make the patient more comfortable, to assist nature in healing the patient's illness, and, in cases of serious and chronic illnesses, to make the load as easy as possible, and help the patient to function as well as his limitations will permit. If we would be willing to accept the same modest ideals in the practice of psychotherapy, then our knowledge is quite sufficient to achieve such a goal. We must be aware of the limitations of our method, but, on the other hand, we can help more people, we can make our therapy more available for larger groups even though we forego the pleasure of effecting complete personality change in a few patients. The relinquishment of this latter goal is accompanied to some extent by the regret of giving up our own feeling of omnipotence.

It may be well to illustrate my point of view with the case reports.

#### REPORT OF CASES\*

CASE 1.—A woman in her thirties, who had been married for a year, came to me because she had been very upset for the past month. Her husband was an army officer on the Atlantic Coast, and she wanted to join him as he was more or less permanently stationed in one of the big army camps there. The patient was overjoyed at the idea of being with him since they had been separated shortly after marriage by the war. She made preparations to complete her job as a bookkeeper in a large wholesale house, and planned to join her husband within the month. Suddenly she felt she was unable to do so. She entirely lost her energy, could not seem to complete her job, would cry at her work and could not bear the idea of leaving her mother and sister with whom she had lived in close association for the past 20 years. She had occupied the same house for many years, she had had the same job since her graduation from business college, and she had developed a very fixed routine of work from which she never departed. She was a skillful and efficient bookkeeper, and had not thought much about marriage until she was getting into her thirties, when she met the man who fell in love with her and with whom she fell in love. She was very happy in the engagement period and in the first few months of marriage until her husband left for the army camp. It never occurred to her that she would have difficulty in leaving home and joining her husband. It was a shock to her that she had doubts and misgivings about leaving the city.

When I saw her she was crying, told me that she had lost her appetite and ambition, could not work, and constantly ruminated about the fact that she was so disloyal, and that she could not make herself finish her work and join her husband. It was quite obvious that the patient was suffering from a depression in somewhat of an obsessive personality. In the first interview, she wanted to discuss symptoms more and more, as well as the various elements that entered into her conflict. She was getting rapidly worse as her sense of guilt was mounting. I decided it would be best for the patient if she had a small immunizing experience, which would prepare her for the major breaking off from the family. The patient was a large, husky girl and I asked her if she took part in athletics. She told me that she was an en-

\* A third case report will be given in the author's reprints.

thusiastic hiker, but that she had not done much walking during the past several years. I sent her away to a small country hotel in the midst of beautiful hiking country, with instructions to hike a great deal, and I gave her sedatives for sleep. Within two weeks the patient improved a great deal, even though she had a stormy time for the first few days. She returned to the city, completed her job within a week, and was off to join her husband. I hear from her occasionally and she is apparently very happy.

## COMMENT

In this case we have undoubtedly a very rigid obsessive individual, and what she really needed was more elasticity in her personality so that she could more easily meet the various stresses of life. The immediate problem, however, was for this girl to overcome her ambivalence, to get over her depression and to join her husband. With the release of her aggression in walking, the trial separation from her family was effective in removing her symptoms, at least for the time being. I see no reason why this patient should not remain a well-adjusted human being who is decent, affectionate, and loyal to her husband. It is quite obvious that any one of you here could duplicate in your practice many similar cases in which you would have been just as successful as I have been; and I do not see that either you or I have to be ashamed of our therapeutic results or doubt their permanence or value.

CASE 2.—Some problems of sex adjustment are extremely easy to treat without the necessity of embarking upon an elaborate procedure of a complete personality review. A young army officer who was referred to me by a genito-urinary surgeon came to me with the complaint that he had erections but no emissions. He stated that he was very happy in married life, his wife was a nurse with whom he had been in love for a year before he married her. Prior to marriage the patient had had relations with her which were very satisfactory. Immediately after the wedding, however, he noticed that no matter how long the intercourse lasted there was in the first place lack of any sensation, and secondly, no emission. He had complete lack of feeling, even though he loved his wife dearly. I told the patient in the first interview that I had no idea what his difficulty was due to, asked him to tell me something about his family. The patient began to talk about his parents, and stated that his mother had come with him from the middle west and had left his father because of trouble during the past few years. In the presence of the patient who was the only son, the mother complained of the fact that her husband was impotent. In so many words she told the boy, my patient, that that was the cause of her unhappiness. As the patient was telling the story he admitted that he had made a resolution there and then that he would do everything in his power to satisfy his wife and that he would not be impotent. He began to look upon intercourse as a responsibility and a duty, especially if it came in married life. As the patient went on telling the story he agreed with me that after his marriage, intercourse became a matter of duty, responsibility, a compulsion and that he resented the fact that he had to do something which was more or less forced upon him, as it had been on his father by his mother. At the end of the interview the patient began to laugh. He called me up the next week and said that everything was O.K. He came in a week later and described in great detail the pleasure his wife and he had had in the sex adjustment they had achieved. Since then his wife has become pregnant.

## COMMENT

Unfortunately, there are many more cases where we have failures rather than successes, and it seems to me that the immediate task of psychotherapy is extensive research into the process of brief psychotherapy. We should collect, very carefully, series of cases where we have success and where we have failure, and especially those cases in which we have failed and someone else has succeeded. On the basis of such careful analysis of all data, we ought to be able to develop intelligent rational techniques for helping our patient both quickly and effectively. All this, however, does not unfortunately eliminate extensive training of the future psychotherapist.

No matter how intelligent, intuitive and kind he may be, the future psychotherapist must receive extensive training in both the obvious and the more subtle mechanisms of therapy. Unfortunately, the psychiatry departments of our universities do not offer any extensive course in psychotherapy. The only places where such training can be obtained are the various psychoanalytic institutes where intensive and well-organized courses in the dynamics of therapy are offered. It is high time that there be a closer liaison between the psychoanalytic institutes and the medical schools.

## SUMMARY

In the past decade neuroses have been more readily recognized by the medical men, and, in response, more effective methods of psychotherapy have been developed. Psychoanalysis has been successful not only in removing symptoms, but in favorable cases affecting profound beneficial changes in the personality of the patient. Good psychotherapists have become somewhat scornful of their favorable results, because they have not been obtained by "deep" psychotherapy. The chairman suggests that the aims of psychotherapy should be clearly defined as in other branches of medicine. Extensive research is needed in utilizing present knowledge for development of quick, effective psychotherapy reaching large groups of patients who are needing it.

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Meeting of California Medical Association in Los Angeles, May 6-7, 1945.—For information concerning this year's meetings, see items in this issue on pages 106 and 137.

# ENDEMIC TYPHUS FEVER IN SOUTHERN CALIFORNIA\*

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AND

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**T**YPHUS fever first came to serious attention in California in 1916 when Mexican laborers, imported to work on railroads, brought the louse-borne disease into the State.<sup>1, 2</sup> Most of the 31 cases occurred in labor camps, and the disease was controlled by delousing and sanitation procedures conducted by the State Board of Health with the coöperation of the United States Public Health Service. Since that time there have been no epidemics of typhus in California. Maxcy<sup>3</sup> records the first case of endemic typhus in California as occurring in San Francisco in 1915 and the second in the same city in 1919. He records the first case in Los Angeles in 1920, followed by four cases in 1921.

The present paper deals with endemic typhus during the period 1922-1942, based upon detailed data on individual cases furnished to the authors by the California State Department of Public Health. The data from 1922 through 1939 were furnished to the senior author in connection with a study of the extension of endemic typhus fever in the southern United States.<sup>4</sup> Since the data provided much more detail than could be presented in that report, it has seemed worthwhile to record it separately, and the California authorities have been kind enough to furnish similar data through 1942. Halverson<sup>5</sup> has reported briefly on the trend of the disease through 1941.

Very recently, Beck, Bodily and O'Donnell,<sup>14</sup> of the Virus Unit, Division of Laboratories, and the Bureau of Epidemiology, California State Department of Public Health, proved the existence of murine typhus in California by isolating a murine strain of Rickettsia from the brain of a rat trapped in a poultry plant located in a semi-rural district of San Bernardino County where a case of typhus had occurred in a woman employed as an egg packer. This is the first laboratory proof of the existence of murine typhus in California.

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## GEOGRAPHICAL AND CHRONOLOGICAL DISTRIBUTION

Table 1 shows the distribution of reported cases by years and their allocation to the probable locality where the infection was acquired. The cases reported as typhus to the State Health Department totaled 216, but one of these in a four-year-old child at Needles, in San Bernardino County, has been omitted from the analysis because of doubt as to its true etiology.

Table 1 shows that of the 215 cases, 152 were allocated to Los Angeles County, 45 to San Diego County, two to Orange County, and one each to the counties of Santa Barbara, San Joaquin, San Francisco and Solano. Among patients allocated to San Diego County are five which apparently contracted the infection at one or another of the race tracks near or just across the Mexican border.

In addition to the counties specified above, seven cases have been allocated to the State of California in general because the source of infection could not be localized, and three cases have been allocated to Texas, one to Hawaii and two to Mexico.

At the foot of Table 1, it is shown that 17 of the 45 patients allocated to San Diego County apparently became infected in San Diego City, and that 125 of the 152 patients in Los Angeles County apparently became infected in Los Angeles City.

The above figures indicate that the problem of endemic typhus fever in California has been, up to the present, limited almost entirely to two southern counties, San Diego and Los Angeles. This is further emphasized by the facts that one of two patients in Orange County may have become infected in Los Angeles County, that the case in San Joaquin County had a negative Weil-Felix reaction, that the case in San Francisco County was a boatman who had visited ports in southern California, and that the case in Solano County was diagnosed only from clinical symptoms. All of these counties except Orange are in central California. Map 1 shows the southern part of California with the number of cases reported from each county in this area.

TABLE 1.—Typhus Fever Cases Reported in California 1922-1942 by Location of Probable Origin

	YEAR																					
	'22	'23	'24	'25	'26	'27	'28	'29	'30	'31	'32	'33	'34	'35	'36	'37	'38	'39	'40	'41	'42	Total
COUNTIES																						
San Diego.....							1					1			5	6	7	4	3	6	13	45
Orange.....																1					2	3
Los Angeles.....	8	15	16		3				1	2	1	2	3	2	3	7	14	24	15	19	17	152
Santa Barbara.....																					1	1
San Joaquin.....													1									1
San Francisco.....							1															1
Solano.....												1										1
STATES																						
California.....	1	1						1						1				1			1	6
Texas.....																2			1			3
FOREIGN																						
Hawaii.....																		1				1
Mexico.....															1						1	2
TOTAL.....	9	16	16	0	3	0	2	1	1	2	1	4	4	3	9	16	21	30	19	25	33	215
CITIES																						
San Diego.....															3	2	3	1	1		7	17
Los Angeles.....	8	14	15		2				1	1		2	2	2	6	6	12	20	9	13	11	125

The chronological distribution of reported cases is also of interest. Considering only the southern part of the State, only one case occurred in San Diego County prior to 1936. Beginning in that year, from three to seven cases occurred annually until 1942, when 13 cases were reported. In Los Angeles County cases increased from 8 to 16 in the years 1922 to 1924. With the exception of three cases in 1926, no more cases were reported until 1930. From then until 1936 from one to three cases were reported each year, after which the annual number has been larger, reaching a peak of 24 cases in 1939.

TABLE 2.—Cases of Typhus Fever in California 1922-1924 and 1925-1942 by Month and Season

Month	1922-1924		1925-1942		Total	
	No.	%	No.	%	No.	%
Jan. .... 1			9		10	4.7
Feb. .... 2	7	17.1	8	22	10	4.7
March ... 4			5		9	4.2
April ... 0			6		6	2.8
May .... 1	1	2.4	18	31	19	8.8
June .... 0			7		7	3.3
July .... 5			13		18	8.3
Aug. .... 3	10	24.4	14	46	17	7.9
Sept. .... 2			19		21	9.8
Oct. .... 11			32		43	20.0
Nov. .... 9	23	56.1	22	75	31	14.4
Dec. .... 3			21		24	11.2
Total ... 41			174		215	

The most interesting point in connection with the chronological distribution in Los Angeles County is the sudden cessation of occurrence in 1925, and the almost complete absence of cases until 1930 when a very gradual increase began. It will be recalled that in the winter of 1924-25 an epidemic of pneumonic plague occurred in the City of Los Angeles.<sup>6</sup> In the control of that epidemic 210,000 rats were trapped and extensive rat proofing procedures were instituted. It seems probable that this campaign not only eliminated the rat and rat-flea sources of plague, but also reduced the corresponding sources of typhus to a level which prevented, for over a decade, the occurrence of more than a few cases in man. The increase beginning in 1937 was practically coincident with that in San Diego County, and also parallels the progressive increase in Texas and the southeastern states.<sup>4,7</sup> The cessation of cases in 1925 also indicates the probability that most if not all of the cases in Los Angeles County from 1922 to 1924 were acquired from rat-fleas rather than from human lice.

In 203 of the cases the data indicated whether the infection was probably contracted in urban or rural areas; 185 indicated an urban source and 18 a rural source. This demonstrated that the problem in southern California, up to the present time, is predominantly an urban one, as in other parts of the country. The occurrence

of some rural cases, however, indicates that a further spread to rural areas similar to that in Georgia and Alabama may occur.

#### SEASONAL DISTRIBUTION

Table 2 shows the distribution of cases by month and season. Separate figures are presented for the years 1922 to 1924, and for 1925 to 1942. It will be seen that October is the month of highest incidence in both periods, with November ranking second. In both periods the autumn months show the highest incidence and the summer months the second highest. In the period 1925 to 1942 the spring months ranked third and the winter months fourth. In the period 1922 to 1924 a smaller proportion occurred in the spring than in the winter months, but the number of cases is too small to make this difference significant. This seasonal distribution conforms in general to that of murine typhus in the southern United States, and is quite the opposite from louse-borne typhus in temperate zones, where the incidence is highest in winter and spring. It supports the probability that most of the cases from 1922 to 1924 were flea-borne rather than louse-borne.

TABLE 3.—Cases of Typhus Fever in California 1922-1942 by Age Groups

Age Groups	Cases	%
0-9	1	0.5
10-19	20	9.5
20-29	49	23.1
30-39	57	27.0
40-49	30	14.3
50-59	33	15.6
60-69	20	9.5
70-79	1	0.5
Total	211	100.0

#### DISTRIBUTION BY AGE, SEX AND OCCUPATION

Table 3 shows the distribution of cases by ten-year age groups. Four cases of unknown age are omitted from this table. It will be seen that the largest percentage of cases occurred in the 30-39 age group, with the age group 20-29 ranking second, 50-59 ranking third, and 40-49 ranking fourth. This proportionate distribution of cases in age groups does not of course indicate the relative incidence of the disease in the corresponding age groups of population. Such an analysis, based upon the age distribution of the population, would probably show the highest incidence in later age groups. An analysis by sex shows that 73 per cent occurred in males and 27 per cent in females. This corresponds to the relative sex incidence in murine typhus in other parts of the country.<sup>8</sup>

Table 4 shows the distribution of cases by general type of occupation. The largest single group comprises housewives. Their principal place of exposure would be expected to be in the home, and the same can be said of children and students, although in neither case can infection elsewhere be excluded. All of the other occupational classifications, which together comprise the great majority of the cases, indicate the probability of

infection in their occupational locations, although infection of some of these persons may have occurred in the home. Further examination of the data on the 58 female cases indicated that only a minority (25) were housewives, and eight were children and students, while 19 of the remainder were engaged in gainful occupations where they might have been exposed to rats.

TABLE 4.—Cases of Typhus Fever in California 1922-1942 by Occupation

Occupations	Cases
Housewives	25
Factories, Warehouses, Docks, Boats	24
Stores and Markets	21
Service Trades, Salesmen	21
Office, Professional, Teaching	17
Eating Establishments, Food Processing	14
Ranches, Farms, Horses	13
Children, Students	13
Railroad Workers, Laborers	10
Unemployed	9
Other	18
Unknown	30
Total	215

With reference to exposure to lice, the epidemiological data stated such possible exposure in 17 cases, but in 14 of these, possible exposure to rats was also indicated. It is interesting that the first mention of contact with rats is in connection with a case occurring in 1924, two years before the publication of Maxcy's paper<sup>9</sup> suggesting a rat reservoir of endemic typhus. The second mention of rats is in connection with the 1932 case, after which contact with rats was frequently mentioned. Conditions favoring exposure to rat-fleas are, however, described in connection with many of the earliest cases.



Chart 1.—Map of Southern California showing number of cases of typhus fever reported from each county, and from Los Angeles and San Diego cities, 1922-1942.

#### METHODS OF DIAGNOSIS AND CASE FATALITY

The Weil-Felix test was performed in 187 cases. In 40 of these the reaction was positive but the titer was not reported. In 135 the reaction was positive in a serum dilution of 1 to 160 or greater. In 9 it was positive in a dilution of less than 1 to 160, and in 3 it was negative. In 25 cases the data did not state whether or not the Weil-Felix test was performed. One case was proven by guinea pig inoculation and 1 case was stated to have been diagnosed on clinical symptoms alone.

There were 7 deaths in this series, or a case fatality rate of 3.2 per cent. The ages of the fatal cases were as follows: 27, 40, 47, 54, 57, 58 and 69. Except for the 27-year-old case, these conform to the usual age distribution of fatal cases of murine typhus in the United States.<sup>8</sup> The 27-year-old case occurred in a Filipino in Solano County, north of San Francisco. The diagnosis was based entirely on clinical observations.

#### ADDITIONAL POINTS IN EPIDEMIOLOGY

In 13 instances more than 1 case occurred in the same household in the same year. In 10 of these instances there were 2 cases and in 3 instances there were 3 cases in the same household. The time intervals between the onset of cases in the same house ranged from 3 days to nearly one year.

In 2 additional instances personal contact was reported between cases at close intervals, the patients not living in the same house. One of these instances involved 4 men who became ill within 3 weeks; 2 of them were partners in a shoe store. The other instance involved a female attendant in the San Diego County Hospital who became ill after being in contact with a case in the hospital for a period of seven weeks.

Cases on ranches or farms, or connected with race tracks on the Mexican border, were reported only since 1936. This suggests that the reservoir of infection has recently spread into rural areas, partly from the large cities and partly from northern Mexico.

The 3 cases allocated to Texas were in persons who apparently were exposed in traveling by motor car to California. The case allocated to Hawaii was in a white woman who crossed the Pacific from Shanghai, stopped in Honolulu, and was ill upon arrival in San Francisco. The first case allocated to Mexico was in a woman who became ill 3 days after returning by automobile from Mexico City. The second case was in a mining engineer who was ill on arrival from Mexico. Both of these may have been louse-borne cases.

One case occurred in a Russian Jew, age 32, who stated that he had had typhus in Russia 20 years previously. This is of interest in view of the opinion of Zinsser<sup>10</sup> that Brill's disease in the northeastern seaports of the United States represents an exacerbation of Old World typhus in individuals who acquired the louse-borne disease previous to emigration to this country.

#### COMMENT

The data reported in this paper indicate that the problem of typhus fever in California is still limited primarily to Los Angeles and San Diego Counties, particularly to the large cities, and that there is an increasing problem in those areas, the largest number of cases to date having been reported in 1942. The locally acquired disease is entirely the murine variety and probably has been so almost entirely since 1922 or before. Within the last few years a larger proportion of the cases than previously have occurred outside the cities

of Los Angeles and San Diego, indicating that the rats in rural areas are acquiring a high incidence of infection.

The State of California and many of its cities, with the cooperation of the United States Public Health Service, have carried on efficient rat control programs for the control of plague for many years. This has undoubtedly been responsible for the relatively small number of cases of endemic typhus which have occurred, for the postponement of the increase of cases in California beyond the time when the increase in Texas and the southeastern states began, and for the present confinement of cases to the southern part of the state. The reasons for the recent increase in Los Angeles and San Diego and the spread to rural areas are probably an increase in the proportion of rats infected with typhus, and an increase in the proportion of rats infested with the so-called tropical rat-flea, *Xenopsylla cheopis*, one of the most efficient vectors of murine typhus<sup>7</sup> as well as of plague. This species of flea has been found on rats in most localities where it has been sought in connection with cases of endemic typhus. Within recent years it has been found in a number of northern cities in the United States.<sup>11</sup> Since the only possible control of the flea is through the control of the rat, it is probable that the only method of preventing a further increase of endemic typhus in man and its extension to other cities and rural areas is through more intensive rat control measures. Rat-proof construction of new buildings, supplemented by the relatively inexpensive methods of vent stoppage and elimination of rat harborage in old buildings, developed by the Georgia State Department of Health<sup>12</sup> and the United States Public Health Service,<sup>13</sup> will probably be required in order to reduce the rat population to a point where endemic typhus in man will rarely occur.

#### SUMMARY AND CONCLUSIONS

1. An analysis is presented of the occurrence of endemic typhus fever in California. The disease to date has occurred almost entirely in the southern portion of the state, the chief endemic areas being Los Angeles and San Diego Counties, and particularly Los Angeles and San Diego cities.

2. The locally acquired disease is the murine type and has probably been so almost if not entirely since 1922. This is indicated by the sudden disappearance of the disease in 1925 following the vigorous rat-control campaign in Los Angeles in connection with the epidemic of pneumonic plague. It is also indicated by the seasonal, sex and occupational distribution of cases, the low case fatality rate and the general absence of human lice on patients.

3. The recent occurrence of a larger proportion of cases in rural areas, particularly associated with hog ranches and race tracks, suggests that the disease in rats is becoming more prevalent in rural areas.

4. Although the incidence of human cases of

murine typhus in California is not yet alarming, its increase in recent years emphasizes the necessity for the continuation of vigorous rat-control measures in the cities and thickly populated rural areas of southern California, and also in cities farther north which may become endemic foci in the future.

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#### MADUROMYCOSIS OF THE ANKLE

##### REPORT OF CASE

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IN North America Maduromycosis (Madura foot, mycetoma) has been a rare and little-known disease, in contrast to India and the Dutch East Indies where it is prevalent and well-recognized. Because (larger) numbers of men from the United States will be exposed to infection by the fungi which give rise to Maduromycosis, it seems appropriate at this time to report a case recently seen in a U. S. Naval Hospital.

##### REPORT OF CASE

R. R. R., CK3c, Filipino, aged 40 years. Entered hospital, Oct. 25, 1943.

Complaint: Swelling inner aspect of left ankle, seven months.

**Past History:** Born in Philippine Islands. Lived on the Island of Luzon until 16 years of age, in the Hawaiian Island until 18 years, and in the United States since, except for the past ten months which have been spent in the Alaskan area. No recent illnesses or operations.

**Present Illness:** About seven months ago the patient first noticed a small nodule on the inner aspect of the left ankle just below the internal malleolus. Two months later it broke down and discharged with subsequent healing of the skin. The mass has increased rapidly in size and at present is about 7 cms. in diameter.

**Physical Examination:** T. 98.4°F., P. 74, R. 18, Bl. Pr. 116/74. Examination is essentially negative except for the left ankle. Here there is a nodular mass situated in the subcutaneous tissue, with no changes in the overlying skin. It is well circumscribed, and freely movable except for slight adherence to the deep fascia. No inguinal lymphadenopathy. An x-ray film shows a soft tumor overlying the internal malleolus with no bone changes evident.

**Laboratory Studies:** Blood: Kahn—negative. R.B.C.—5,370,000; Hgb.—15 grams; W.B.C.—5,900. Urine: Negative.

**Course:** Operative excision of mass was performed on Oct. 29th, under spinal anesthesia. The mass was attached to the fascia over an area 4 x 5 cms. At operation, the tumor appeared slightly lobulated, nonencapsulated, and solid. (Clinical diagnosis, "D.U. (Fibroma, left ankle)").

**Surgical Specimen Report:** Gross specimen consists of an ellipse of skin 6.8 x 1.8 cms. which covers on one aspect a subcutaneous mass 6.5 x 3.5 cms. in size and 1.5 cms. in thickness. Upon cut section, the latter consists of islands of fatty yellow tissue surrounded by strands of tough grayish white fibrous tissue. The freshly-cut surface reveals numerous small yellowish areas of necrosis measuring up to 0.5 cms. in width, which centrally contain tiny black granules (Figure 1). *Histological examination* shows numerous subcutaneous abscesses containing not only a myriad of polymorphonuclear leukocytes, but occasionally large mycelial masses of closely-grouped fungi (Figure 2). About the periphery of the "granule" there is considerable dark brown pigment, contained within the fungi. Within the "granule" also are interwoven filaments, hyphae, and conidia (Figure 3). The histological diagnosis is "Maduro-mycosis, subcutaneous tissue, ankle, melanoid variety, (Madura foot)".

**Bacteriological Studies:** Inasmuch as the tumor was considered to be neoplastic, the specimen was fixed in formalin, thus precluding cultural studies. Exuding serum from the wound, cultured on the first postoperative day, showed no fungus growth.

**Postoperative Course:** Exuding serum cultured Oct. 30th, revealed no growth of either bacteria or fungi.

Potassium iodide, ggts. x, t.i.d., was given for one week, followed by sulfathiazole, gr. xv q 4 hours, for one week. By November 5th, the wound had healed per primum, and the patient was subsequently returned to duty as cured.

#### DISCUSSION

In 1933, Gellman and Gammel<sup>1</sup> published a table of nine authentic cases of maduromycosis reported in the United States, all but eight having been recorded since 1921. Essentially, the disease is one of tropical and subtropical countries, although sporadic cases have been recorded from both American continents, Europe, and Africa. Maduromycosis is endemic in India where a large majority of the cases involve primarily the feet. The organisms responsible for the disease are believed to be distributed mainly in the soil. It is of interest to bear in mind that India is largely an agricultural country, and to note that most of

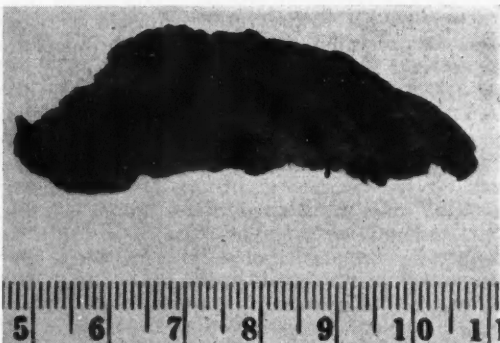


Fig. 1.—Cross-section of mass removed from ankle. Note the multiple subcutaneous abscesses containing black ("melanoid") granules.

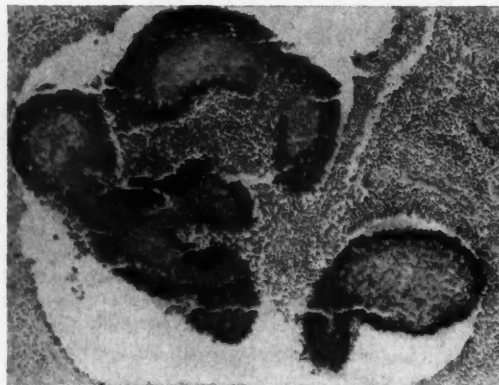


Fig. 2.—The mycelial mass of fungi constitute so-called granules which peripherally are pigmented. The fungi are contained in an abscess which also contains numerous polymorphonuclear leukocytes. (x100).

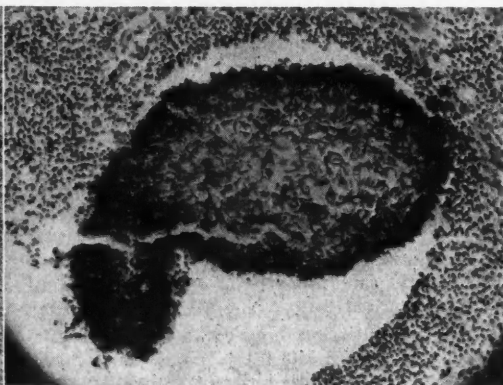


Fig. 3.—Same as figure 2. The "granule" or mycelial mass shows a prominent peripheral zone of pigmentation, and consists of interwoven filaments, hyphae, and conidia. (x400).

the cases reported from India<sup>2</sup> are found in the working-class population who do not have the protection afforded by shoes. It is believed that the association of injuries, noticed or unnoticed, of the bare feet with the causative fungi in the soil accounts for the frequency of infection of the feet. In 1846, the name "Madura foot" was first used by Colebrook<sup>3</sup> of the Madura Dispensary in India, to designate a disease of the feet which was prevalent in that geographic region. Discovery of fungi as the etiologic agents awaited the study of Vandyke Carter<sup>4</sup> in 1860 and introduction of the term "mycetoma" (fungous tumour). For a time actinomycosis was confused with maduromycosis and frequently referred to also by the term "mycetoma." Since Bollinger's<sup>5</sup> discovery that the higher filamentous bacteria, actinomycetes (ray fungus), constitute the etiologic agent for actinomycosis, various studies have shown quite conclusively that even though a rather wide range of species may be responsible for any given case of the two diseases, maduromycosis is caused by more complex organisms, namely moulds belonging to both the fungi imperfecti and the ascomycetes. Thus, maduromycosis is caused by any one of a variety of moulds.

Clinically, actinomycosis and maduromycosis are quite similar in many respects. Both are productive of abscesses containing "granules" which consist of dense masses of the etiologic organism. In actinomycosis the abscesses contain the characteristic "sulphur granule," in contrast to maduromycosis where the granules may be either black (melanoid) or light yellow (ochroid). Microscopically, the actinomycotic granule shows the characteristic formation of "clubs" on the distal ends of the ray-like filaments, whereas in the granule of maduromycosis one is able to identify poorly-staining hyphae, chlamydospores, and conidia. Depending upon the variety, melanoid or ochroid, there may or may not be peripheral pigmentation of the mycelial mass comprising the granule.

In 1943, Shaw and MacGregor<sup>6</sup> reported a case due to *Monosporium Apiospermum*, and cited the paper by Gammel<sup>7</sup> in 1927 where nineteen species of moulds belonging to both the fungi imperfecti and the ascomycetes are listed as having been identified as etiological agents in reported cases of maduromycosis. For the purpose of review, Gammel's list is quoted as follows:

<i>Fungi imperfecti:</i>	
Genus <i>Madurella</i> .....	8
" <i>Indiella</i> .....	3
" <i>Glenospora</i> .....	2
" <i>Scedosporium</i> ( <i>Monosporium</i> ) .....	2
<i>Ascomycetes:</i>	
Genus <i>Allescheria</i> .....	1
" <i>Aspergillus</i> .....	1
" <i>Sterigmatocystis</i> .....	1
" <i>Penicillium</i> .....	1

It is further of interest to note that in the above series black granules were found in those cases where the etiologic agents were *Madurella*

*Americana*, *Madurella ikedai*, and *Aspergillus nidulans*.

The onset of maduromycosis is insidious, its course is slow, and progress is by extension. In contrast to actinomycosis which pursues a more rapid clinical course, and which responds to sulfa-therapy, maduromycosis is still resistant to chemo-therapy, and is best treated by early diagnosis and complete surgical excision.

#### SUMMARY

1. A case of maduromycosis of the melanoid variety is reported, involving the left ankle of a Filipino forty years of age.

2. The mycotic lesion had been present for at least seven months. Early in its course the overlying skin had ulcerated for a short time, but subsequently healed.

3. Upon surgical dissection the lesion was found to be circumscribed and subject to complete excision. No distant lesions are evident.

4. Etiology is briefly discussed.

U. S. Naval Hospital.

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#### MEDICAL EPONYM

##### *Sudeck's Atrophy*

Dr. Paul Sudeck (b. 1866), professor of surgery at Hamburg, was the author of a paper, "Ueber die acute entzündliche Knochenatrophie [Concerning Acute Inflammatory Atrophy of Bone]," published in the *Archiv für klinische Chirurgie* (62:147-156, 1900). A portion of the translation follows:

"The . . . bone atrophy that occurs in association with acute inflammatory affections of the bones and joints occupies a special place in my opinion, and is essentially different from the simple atrophy of disuse. In the latter, for example, atrophy occurs to any considerable extent only if the functional stimulus has been lacking over a long period of time,—at least a few months,—whereas in what I have referred to as acute inflammatory affections of the bones and joints a significant degree of atrophy takes place in a remarkably short period of time, not only indeed in the bones directly involved, but also in the neighboring bony structures that are functionally related to the diseased bone."—R. W. B., in *New England Journal of Medicine*.

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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## OFFICIAL NOTICES

### EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

*Minutes of the One Hundred and Ninetieth (190th) Meeting of the Executive Committee of the California Medical Association\**

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco on Wednesday, January 31, 1945, at the noon hour.

(By mail vote, the minutes which follow received approval by all members of the Executive Committee.)

#### 1. Roll Call:

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; and Mr. Clem Whitaker of the firm of Clem Whitaker and Leone Baxter (California Feature Service).

#### 2. Proposal to Print and Mail Informative Bulletins Concerning Pending Compulsory Sickness Insurance Bills Before the California Legislature, to All Members of the California Medical Association:

Council Chairman Gilman called attention to the desirability of printing a weekly or bi-monthly bulletin to be mailed to all C.M.A. members, such bulletin to present up-to-date information concerning sickness insurance and associated medical practice and public health legislation that has been submitted to the 56th California Legislature now in session.

After discussion, it was agreed that it was very important that a definite program should be maintained through which would be brought to the attention of every member of the California Medical Association, the importance of the issues at stake in the compulsory sickness insurance and other legislation now pending.

It was agreed that this bulletin should be put out by the C.M.A. central office in line with action taken at the meeting of the Executive Committee held on January 21, 1945, whereby a special coordinating and liaison subcommittee for the C.M.A. Committee on Public Policy and Legislation was authorized.

#### 3. Discussion of Publicity From a Technical Standpoint:

Mr. Clem Whitaker of San Francisco, representing his firm of public relations agents, was requested to give his opinion concerning the pending legislation.

Mr. Whitaker gave a presentation of his observations of the compulsory sickness insurance legislation, in relation to political and other forces, as based on his former experiences with such projects.

It was agreed that the firm with which Mr. Whitaker is connected should be employed to work in conjunction

† For complete roster of officers, see advertising pages 2, 4, and 6.

\* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

with the special C.M.A. coordinating committee on legislative activities, as supervised by the C.M.A. Committee on Public Policy and Legislation and its representatives.

Considerable comment was made on certain technical phases of publicity and public relations, and it was agreed that the suggestions submitted should be carefully considered, and if deemed advisable, put into action.

#### 4. Adjournment:

There being no further business, on motion made and seconded, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman*,  
GEORGE H. KRESS, M.D., *Secretary*.

#### OFFICIAL NOTICES

##### PROPOSED AMENDMENT TO CONSTITUTION

(Presented at Los Angeles by Lowell S. Goin. For reference, see *CALIFORNIA AND WESTERN MEDICINE*, for June, 1944, page 297.)

##### Re: Past President

*Resolved*, That the Constitution and By-Laws of the California Medical Association be amended as follows:

In Section 1 of Article VII delete the words "Past-President";

In Section 8 of Article VII delete the words "Past-President";

In Section 1 of Article X delete the words "Past-President";

In Section 2 of Article X delete the second paragraph reading as follows:

"At the expiration of his term of office the president shall become the past-president and serve as such for a term of one year thereafter, or until his successor assumes office."

In Section 4, Article X delete the words "Past-President";

##### PROPOSED AMENDMENT TO CONSTITUTION CONCERNING RETIRED MEMBERS

(Presented at Los Angeles meeting of the House of Delegates by C.M.A. Council. For reference, see *CALIFORNIA AND WESTERN MEDICINE*, for June, 1943, on page 349.)

Amend Article IV, Section 1(c) of the Constitution of California Medical Association:

The Section 1(c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said section 1(c), a full new paragraph:

If an application for retired membership is submitted by a competent medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1(c) of Article IV will therefore read:

##### (c) Retired Members:

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

Then follows the portion before read, the provision being made therein, Mr. Speaker, to make it possible for the Council to act upon these applications. Many of these applications are submitted in January and February of a succeeding year. Under the present By-Law, applica-

tions can be considered only when the applicant has active membership. In any calendar year, if dues are not paid on or before April 1st, active membership then ceases as of date of April 1st.

#### PROCEDURE CONCERNING AMENDMENTS TO C.M.A. CONSTITUTION

##### ARTICLE XV.—AMENDMENTS

##### Section 1.—Procedure to Amend Constitution

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the official journal of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two thirds of the Delegates present and voting vote in favor thereof, the same shall be adopted.

#### CHAPTER III

##### RE: COMPULSORY HEALTH INSURANCE BILLS PENDING IN 1945 CALIFORNIA LEGISLATURE (56TH SESSION)

CALIFORNIA AND WESTERN MEDICINE for January, 1945, on pages 1-4 and 25-40 presented informative comments and items dealing with proposed Sickness Insurance laws for California.

In the issue of February, on pages 51-53 and 64-92 the items were continued as Chapter II of the series.

In the present number of CALIFORNIA AND WESTERN MEDICINE the sequence is continued as Chapter III. (See pages 124 to 136.

\* \* \*

#### INDEX OF SICKNESS INSURANCE ITEMS

Pages 123 to 124

(The index of "Chapter I" of Sickness Insurance items, appeared in *CALIFORNIA AND WESTERN MEDICINE*, for January, on page 40. The index of "Chapter II," appeared in the February issue, on page 64. What follows, is Chapter III.)

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### ITEM I

#### Governor Warren's Program—How Does He Get That Way?

If you count the next part of the legislative session as a battle—and it promises to be one of the biggest in State history—this month of February becomes the critical period of consolidating lines, amassing supplies, preparing to pass the ammunition. The undramatic period civilians are apt to dismiss as "phony war." Don't mistake it. The issue of Governor Warren's program rests largely on what supplies and strength, what civilian interest as well as "pressure group" interests are aroused during the next four weeks.

Few legislative interims have been as important to Californians; for few governors have proffered a program that means so much, so intimately, to the millions of private citizens.

Governor Warren has chosen the field of battle and picked his own position on the terrain. Others at Sacramento had some of the same points in mind. But he got there "furthest"; whether he has the "mostest" remains to be seen.

The Governor sketched a large program—prepaid medical care; expanded unemployment insurance; improved and speeded workmen's compensation; new department of mental hygiene. . . .

These, together with disposition of taxes and surplus funds and a highway program, will be the main objectives in the coming political battle.

And the question in many minds is—how did Earl Warren, national Republican figure who keynoted the G.O.P. convention and turned down the rôle of vice-presidential candidate, become the general of such forces, the leader on such issues? How did an Alameda district attorney, nurtured in conservative Republicanism, a G.O.P. attorney general, become in a few years the champion of a "peoples' program."

There is a jibe in Sacramento that Governor Warren found his January 8 speech in some desk drawer left over from the Olson Administration. Democrats complain that he lifted more than half their party platform. But they came around to promising support.

"The program contains principles we have advocated for years," said William Malone, Democratic state committee head. "We certainly won't oppose them just because Governor Warren offers them. We'll be there fighting for them."

There are strange paradoxes in California's political situation. The State is preponderantly Democratic in registration and voting strength. But the State Administration is Republican, the majority in both legislative houses is Republican. This would suggest that a Republican governor should be able to get what he wants, especially when he offers a program to answer a popular need.

Yet Republicans have not made a commitment of support. Many in the Legislature are confused. They are astonished at such legislation emanating from a Republican source. They were unprepared for such liberal philosophy. They are suspicious that Governor Warren has

in mind only his own political future, and is making a bid for popular support by mimicking demands of the powerful C.I.O. They are uncertain whether to credit his audacious proposals to political expediency; or to concede that they may be an accurate interpretation of what people want.

And into the Legislature's attitude towards the Warren program enters another element. Party affiliation actually means less in that body than individual staying power. Through power of one sort or another, through ambiguous cross-filing, through close attention to community needs, many men have stayed in the Legislature a long stretch of years. Even now districts which went for Roosevelt in the national election returned men with reactionary voting records to the Legislature; districts which voted for Governor Warren three years ago have done the same.

Governors, on the other hand, have pretty short terms in California. For more than 30 years, no governor has been returned for a second term. Men who have sat through the Legislature 10 and 20 years have seen Republican governors come and go. There are many such perennials in the Senate, quite a few in the Assembly, and most are powerful. They are accustomed to great independence towards the State executive. They can and often do turn thumbs down on a Governor's program, especially in the second session. They assume it to be his last.

Governor Warren's program is unlike those which Republican governors have been accustomed to offer since Hiram Johnson's time. Tax adjustments, budget refinements, technical administrative improvements were the main achievements of the G.O.P. governors who succeeded each other since 1917. Only Democratic Governor Olson asked legislation on such popular measures, but he did not win a sympathetic hearing. He was incapable of giving his program leadership.

How did Governor Warren "get that way"?

If he has taken some orientation from the aims of that lone Democratic Administration, it has probably come through Atty. Gen. Kenny, a Democrat but avowed supporter of Governor Warren's "non-partisan" approach to State politics. He keeps close to Governor Warren on an "exchange of ideas" basis.

In addition, Governor Warren probably knew before he drafted his speech, that prepaid health insurance, as well as increased unemployment insurance coverage, and some "fair employment practices" committee were to be "do or die" issues with the C.I.O. He knew, and he took the ideas. But he moderated them.

He has managed to incorporate into his own program practically all of the important demands of the hour. Politics or perspicacity? Which ever, the people stand to benefit.

In seeking to explain the Governor's interest in a "peoples' program" some credit his sense of responsibility as the father of a large and never very affluent family. Many times Governor Warren's discussion of some public issue has been in terms of a "family man." In a discussion of women's working hours on one occasion, it was evident he thought in terms of the energy of his own daughters, and the protections they would need. In explaining the need for health insurance he once remarked, "I know I would have appreciated such protection for my family." This attitude may contribute somewhat to his promotion of a popular program. At least it gives a tone of deep sincerity.

There are very few in Sacramento unconvinced that the Governor is personally back of his own proposals. His candor when he says "I know the people need health insurance" is apparent. He promises to battle through to victory.

As one department head put it, "He feels it way down

deep. He has convinced himself and he is out to convince the world. He has hit the sawdust trail"—Mary Ellen Leary, in *San Francisco News*, February 7.

#### ITEM II

### Huge Medical Program Proposed to United States Senate

Washington.—(UP).—This country has been neglecting its health for years—witness the nearly 9 000 000 men of military age who are unfit for military service—and a Senate subcommittee proposed today that something drastic be done about it as soon as possible.

It proposed a gigantic, multi-billion-dollar health and medical-facilities program to be worked out now and put into effect "as soon as materials and labor become available" in the reconversion period.

The program, involving close federal-state cooperation, would reach into every community in the nation and would make available to all citizens not only curative medical care but also preventive and diagnostic services now lacking or inadequate in many sections and levels of society.

#### Proposals Made

The proposals were offered in an interim report by the Senate subcommittee on wartime health and education on the basis of findings assembled at hearings during the last year. The subcommittee, headed by Sen. Claude Pepper, D., Fla., heard scores of witnesses representing the U. S. Public Health Service, the American Public Health Association, the American Medical Association, the Army and Navy, and the selective service system.

Recommendation No. 1 is for Federal grants-in-aid to states now to assist in postwar construction of hospitals, medical centers, and health centers in accordance with State plans approved by the public health service.

This program for what the subcommittee called "a coordinated network of medical centers" in states and communities would involve initial expenditure of \$2,000,000,000 for construction and supplies, according to testimony by Surgeon General Thomas Parran.

#### Proof Submitted

The subcommittee cited as proof of the need for such a program the following data assembled during its investigations:

1. More than 23,000,000 Americans in 1935 had a chronic disease or a physical impairment.
2. Illness and disability cost the country more than 600,000,000 man-days a year.
3. From Pearl Harbor to Jan. 1, 1944, job accidents took the lives of 37,600 U. S. workers, 7,500 more than the military dead for the same period.
4. About 4,500,000 young Americans have been classified 4-F. In all, the subcommittee said, "it is estimated that at least 40 per cent of the 22 000 000 men of military age—between 8,000,000 and 9,000,000—are unfit for general military duty."

Public health estimates, the subcommittee said, show that the nation needs facilities for 100 000 new general hospital beds, 94,000 new nervous and mental hospital beds, and 44,000 tuberculosis beds.—*Santa Ana Register*, January 4.

#### ITEM III

### Health Insurance Answers Sought

#### Assembly Group to Hold Hearings on Bills Before Legislature

When the public health committee of the Assembly begins a series of hearings next week on proposed State health insurance legislation it will seek the answers to questions raised in connection with the half-dozen measures on the subject pending before the Legislature.

Chairman Fred Kraft of San Diego has announced the opening session for the committee at San Diego next Tuesday. The committee will hold a three-day hearing in Los Angeles beginning February 15.

#### Programs Presented

Health insurance measures before the Legislature include one sponsored by Governor Warren, one presented at the request of the California Medical Association, another backed by the C.I.O., and a series of bills presenting the views of the California Farm Bureau Federation. There are others.

There are several general questions common to all State health insurance proposals that will be answered by the Legislature:

Should we have State health insurance at all?

If we have it, should participation by the individual be on a voluntary or compulsory basis?

Who should pay and how?

What services shall be rendered the insured?

If we have compulsory State health insurance, what becomes of the estimated more than a million persons in California already covered with health insurance either through policies which they purchased from the regular insurance companies or through some form of group insurance?

#### Have Varying Ideas

Those are a few of the main questions the people will want the answers to before they commit themselves on the issue: Do you favor State health insurance?

Already members of the Legislature have found that individuals have widely varying ideas of what State health insurance can or will do for them. Some of the lawmakers are sending out postcards to find what their constituents want in the line of health insurance. . . . —*Chester G. Hanson*, in *Los Angeles Times*, February 7.

#### ITEM IV

### C.I.O. Health Bill Analyzed

#### Union-Backed Plan Goes Beyond Warren Idea in Some Phases

The compulsory State health insurance measure backed by the C.I.O., Assembly Bill 449, is, in objectives and general terms, like that urged by Governor Warren, but is more extravagant in some of its detailed provisions.

This bill would cover all those employees who are covered by State unemployment insurance, as would the Governor's bill, but it goes farther and includes all persons who are receiving State aid, such as old age pensioners. It would include unemployed persons and make them eligible for benefits not only for the year in which they are paid up but for a year after. It also will include persons receiving Federal aid in any form when appropriate Federal legislation is passed. Employees of the State, cities and counties also would qualify. . . .

In one very important particular the C.I.O. bill differs from the Governor's bill: it calls for payments to be made to the doctors on the per capita basis, except as to special services and laboratory work where the fee system would be used. That is, a doctor agrees to care for patients at so much a head for a given period of time. The Governor's bill calls for the fee system all the way around. The C.I.O. bill, in addition, will distribute among the doctors those persons who have not selected their own doctor in "due time," a chore to be done by an area medical director.

A spokesman for the C.I.O. said their bill will provide for group insurance participants. That is, such groups that have their own laboratories and plant, clinics and the facilities to serve their patients may qualify with the commission. But mere associations of doctors giving a service as individual doctors, could not qualify, said

the spokesman. The individual would be subject still to the 1½ per cent pay check deduction.

Periodic physical examination would be given under the terms of this bill but not in the Governor's bill. That, of course, brings up the question of what the examination is to consist and how much will it cost—a matter seemingly left for the commission or board of doctors to set forth.

The bill calls upon the commission to study ways and means of bringing farmers, agricultural labor, self employed and all others under the provisions of State health insurance—Chester G. Hanson in *Los Angeles Times*, February 8.

#### ITEM V

##### Doctors' Health Bill Analyzed

###### *Financial Inducements Proposed to Encourage Voluntary Joining*

The California Medical Association is sponsoring Assembly Bill 1200, which proposes health insurance on a widely different basis from that proposed in other measures.

The doctors propose that instead of making State health insurance compulsory, certain financial inducements be held out to the individual to encourage him to join some form of group insurance or approved health or hospital prepayment plan.

They propose to let the individual use his unemployment insurance payments, in part, and any benefits he may be entitled to, to help pay his doctor bills.

###### Voluntary Basis

They place participation in such plans on a voluntary basis. If you don't want such insurance you don't have to take it. However, even though a person does not participate in one of the approved group or prepayment plans he shall be entitled to use his unemployment insurance benefits to help pay his doctor or hospital bills under certain conditions.

Other health insurance bills before the Legislature, including that sponsored by the Governor and that by the C.I.O., excepting the Farm Bureau bills, require the individual to participate in the payment of premiums whether he wants the insurance or not (except those declining on religious grounds.) In short, they take it off your pay check and you can use the service the way they propose to give it to you or not.

At present the employee now contributes by way of deductions from his pay check 1 per cent of the first \$3,000 of his salary into the State unemployment insurance fund. The doctors' bill proposes that if an employee now under unemployment insurance joins an approved nonprofit hospital care plan his contribution to the unemployment insurance fund shall be reduced by 15 per cent. If he joins a medical care nonprofit plan his contribution would be reduced by 35 per cent. If he joins a plan that embraces both medical and hospital care approved by the State his contribution to unemployment insurance would be reduced by 50 per cent.

###### Rebate to Pay Care

It is assumed he will use his rebate to help finance his payment on his prepaid medical and/or hospital care plan. This is money that tens upon thousands of employees pay into unemployment insurance funds from which they draw no cash benefits.

The doctors go further in their bill; they propose that if the employee joins no prepaid medical or hospital care plan and becomes hospitalized from illness he then may draw whatever unemployment insurance bene-

fits he would have been entitled to if he had become unemployed. At present he cannot use illness as a reason for drawing unemployment insurance.

What the doctors are saying is: Let's use unemployment insurance premiums and benefits to help out on health insurance. You are free to buy whatever type of health insurance you want and can pay for, or you don't have to buy any and you can still use unemployment insurance benefits for "sickness benefits."

The bill sets up conditions under which sickness benefits can be taken out of unemployment insurance; such as, the employee must be hospitalized for a waiting period of four days, his illness or injury is not caused by his employment (which would be taken care of by workmen's compensation, presumably), and he must be under care of a licensed physician or surgeon.

###### Regulations Proposed

As in the other bills, rules and regulations are set up governing the membership and operation of the group medical or hospital care and the contracts. No new tax is proposed in this bill, either on the employer or the employee.

The doctors point out that objection to reducing employees' contributions to unemployment insurance in California is not well grounded because the fact is that California is one of only four States that require the employee to contribute to unemployment insurance and that all the other States seem to get along all right on the payments the government allows the unemployed.—Chester G. Hanson in *Los Angeles Times*, February 9.

#### ITEM VI

##### New Bill Held Health Insurance Compromise Move

Sacramento, Feb. 11.—Although the main author denies it's intended as an alternative to Governor Earl Warren's health insurance bill, a certain bill introduced in the State Senate by members of an unemployment insurance committee looms as a likely compromise for the anticipated controversies on health insurance.

The bill, SB 1802, sets up a fund from compulsory employee contributions to provide benefits to individuals unemployed because of sickness or injury for which no compensation is made under the unemployment insurance or workman's compensation law.

Purpose of SB 1802 is to compensate in part for wage loss sustained as a result of sickness or injury, rather than to relieve the individual of the burden of medical bills.

###### Alternative Aim Denied

State Senator Jack Shelley of San Francisco, chairman of the committee and main author of SB 1802, denies that the measure was intended as an alternative to Governor Earl Warren's health insurance bill, of which Shelley himself is a coauthor.

However, Senator H. E. Dillinger of Placerville, who is likewise a coauthor of both SB 1802 and the Governor's health bill, says he wouldn't be surprised if the former turns out to be the nearest thing to a health insurance bill to emerge from the 56th session of the Legislature. . . . Peggy Ferris in *San Jose Mercury Herald*, February 12.

#### ITEM VII

##### Labor States Health Views

San Diego, Feb. 13.—Representatives of organized labor today told members of a California Assembly committee that they were 100 per cent in back of any legislation that will offer the working man hospitalization and medical care "without resorting to assembly-line methods."

The committee is conducting a series of hearings throughout the State on the controversial assembly bill that would provide medical services and be financed by a withholding tax.

Speaking for the bill at the opening session were Robert Noonan, secretary-treasurer of the San Diego County Federated Trades and Labor Council; N. R. Pyeatt, president, Aeronautical Machinists (A.F.L.) and Ray Morkowski, of the United Automobile Workers (C.I.O.).

"It has long been our contention that the average employee is not financially able to provide adequate medical care for himself or his family. Only the wealthy and destitute are getting the best of medical care," Mr. Noonan said.

Mr. Noonan said he did not advocate any particular bill, but an acceptable measure should do the following:

1. Cover everybody who might be unable to provide care for himself and family.
2. Offer the best available service, flexible enough to allow individual treatment without resorting to assembly-line methods.
3. Provide much-needed preventative diagnosis and treatment.
4. Go beyond present private insurance.
5. Not be patterned after the "California Physicians' Service."—San Francisco News, February 13.

#### ITEM VIII

#### Health Plan Gets U. S. Eye

Senator James E. Murray (D., Mont.), coauthor with Senator Robert Wagner (D., N. Y.) of a bill for a Federal system of prepaid health insurance declared today, in an exclusive statement to *The News*, that the pattern of health insurance adopted by California "is likely to have far-reaching influence on what happens in other states."

The senator made clear that he hopes for a national system of health insurance—part of a "unified and comprehensive system of social insurance." His and Senator Wagner's "cradle to the grave" bill provides for prepaid medical insurance plus unemployment insurance and old-age insurance.

Senator Murray, in his statement, revealed for the first time that the revised form of this "cradle to the grave" bill, soon to be introduced, will "clarify the relationships between the Federal and State Governments in the administration of the health benefits."

"We intend," he said, "to make it even clearer than it was in our first bill that a state or a state agency can become the administrative branch of the national insurance system, responsible for providing the health benefits to the people of the state."

"The coverage and financing would still be national; the administration of the benefits—that is, the arrangements to provide medical services—would be state and local, within the framework of national policies and standards."

As his remarks reached here, the first public hearing on proposals for a state prepaid medical health plan opened at San Diego. Members of the Assembly public health committee, headed by Assemblyman Kraft (R., San Diego), will be in Los Angeles later this week, then hold further hearings in Fresno. They will have a two-day session here March 2 and 3.

#### Panel Discussion

Meanwhile, the Palo Alto Democrats Club set for tomorrow night at 8 a panel discussion of health insurance by the following speakers: Senator John Shelley, San Francisco; Senator Byrl Salsman, San Jose, on the Governor Warren bill; Dr. Stanley Kneeshaw, member

of the California Medical Association state council, and John Hunton, association executive secretary, on the physicians' bill; Dave Hedley, on the C.I.O. bill. It will be held at the Palo Alto Women's Clubhouse, open to the public.

At a public forum in San Francisco Sunday, Feb. 25, the Lawyers Guild will be cosponsor with the Northern California Union Health Committee, the Physicians Forum, the California Department of the Veterans of Foreign Wars of the United States, the Mental Hygiene Society of Northern California, and the California Conference of Social Welfare.

One question raised about the state proposals has been the possibility of meshing it with any future Federal plan. The present Wagner-Murray bill has a "contract" clause, permitting a state setup to handle operation under broad Federal standards and organization.

While the Federal proposals have been used by some to discourage adoption of a state system, others argue that such programs could be better administered from the state capitol than the national capitol.

#### California Outstanding

He pointed out that a number of states have health insurance bills before their legislatures, but added:

"California is outstanding in giving serious attention to such bills. If one of the bills or some combination of bills should be enacted the pattern that is adopted in California is likely to have far-reaching influence on what happens in other states."

Senator Murray emphasized that his comments are not to be construed as interfering in a situation "primarily or exclusively a concern of the people of California."

His statements were directed "to the point that the present discussions in California are of substantial interest and importance to other states and to the nation as a whole."

The need for health insurance, he remarked, is very great.

"The public is overwhelmingly in favor of it, as public polls plainly show. The principal labor organizations of the country are strongly for it; and they have again and again expressed labor's readiness and willingness to pay contributions into an insurance fund in order to have protection against the costs of adequate health services."

#### Rearguard Action

"The American Medical Association and its political stooge (the National Physicians' Committee) are merely fighting a rearguard delaying action. I suspect they are hoping that if they can have health insurance come slowly enough and with enough muddling, it won't amount to anything when it is adopted and they will be in control of it."

"The doctors," Senator Murray went on, "have a proper rôle to play in the administration of health insurance, and any good plan will give them that rôle. The doctors will have to be the ones to furnish medical care, and every one wants them to have the best possible opportunity to furnish the highest grade medical care they can possibly give all their patients."

"At the same time, health insurance as a whole must be of the people and for the people; the basic and overall control of health insurance must, therefore, remain with the public and not with any limited or special-interest group."

He urged state study of the Federal bill (S. 1161, 1943), saying he considered it laid on "a sound pattern." Revisions now being worked into that "cradle to the grave" measure bring a number of improvements he

said, "suggested by the year and a half of public discussion."

Senator Murray concluded by expressing a hope that whatever legislation California may adopt on health insurance "will follow as closely as possible the general pattern of our national bill, and will contain broad and flexible provisions so that California's system can fit into the national program as soon as such a program is enacted."—Mary Ellen Leary in *San Francisco News*, February 13.

#### ITEM IX

##### California League of Women Voters

Mrs. Max Stern, 1238 14th Avenue, who has been serving as legislative advocate for California League of Women Voters, has been appointed one of the two new directors on the League's State board. Mrs. William Irvine, president of Salinas League of Women Voters, is the other director. Announcement of appointments and important policies adopted by the league was made at the State board meeting last week in Los Angeles.

A medical insurance system which could provide for full curative medical and sickness prevention services of the highest standard for every citizen of the State was urged by the board.

##### Wants Wider Scope

The board in adopting its policy decided that no measure now pending incorporates the wide scope of services, the protection of standards or the safeguards to individual freedom of professionals or beneficiaries to which the league is committed.

The league is pledged to work at the Legislature for the enactment of a law which will provide for:

1. Full medical services including periodic medical examination, immunizations, etc., on the preventive side, and general and specialized medical services, hospitalization, x-rays, drugs, dental services on the curative side.
2. Basic right of patient to choose doctor and of doctor to accept or reject patient, and of doctor to participate in or stay out of plan, and to choose the type of practice he favors.
3. Financing by contributory insurance payments from employers and employees.
4. Fees for payment only for specialists' services; a system of capitation payment for general medical services.
5. Adequate provision for impartial and efficient administration protected against control by any interested group.

##### Part-Pay Plan Approved

The league opposes any system of medical insurance which discourages prompt resort to medical help when necessary, such as the requirement that the patient pay for the first one or more visits, or for a part of the services. . . .—*Sacramento Union*, February 14.

#### ITEM X

##### Health Insurance Demand Debated

The first point in dispute as to the proposed State health insurance plan is whether the people of the State actually want prepaid health service. The fact that this point is brought up indicates the battle will be fought on four lines instead of three.

The three, as mentioned in this column two weeks ago, are:

Whether health insurance shall be compulsory or voluntary;

How the cost shall be distributed; and

How the doctors shall be paid.

Governor Warren, in his message, said: "We have ample evidence that our people desire this protection."

This statement is now under attack. A publicity man for the opposition says: "The only public demand for this costly program (Governor Warren's), so far as can be determined, emanated from a small section of the C.I.O."

Dr. Lowell S. Goin, president of the California Medical Association, asks why, if the people are so loudly demanding prepaid care, don't they come and buy it? Through the California Physicians' Service, he says, it has been available for seven years for less than the proposed payroll tax. They haven't bought it. Why pass a law to make them? . . . —W. L. Blair in *Pasadena Post*, February 14.

#### ITEM XI

##### Doctor Assails Health Proposal

San Diego, Feb. 13. (AP)—Major opposition to the labor-endorsed compulsory health insurance was given here today by Dr. S. J. McClendon, representing the San Diego County Medical Society, before an Assembly committee conducting the first of a series of Statewide hearings on health measures.

Dr. McClendon testified that nearly a third of the State's physicians are now in the armed services and urged that no change be made in the fundamental laws concerning the medical profession until the war ends. He said the society would support all forms of voluntary health insurance.

Compulsory health insurance legislation is long overdue in the opinion of San Diego organized labor, Robert E. Noonon, secretary of the A.F.L. Central Trades Council, testified.—*San Jose Mercury Herald*, February 14.

#### ITEM XII

##### Health Insurance

##### Hearings to Begin on Voluntary and Compulsory Protection Bills

Proponents of the various health insurance plans will present arguments for their measures, both compulsory and voluntary, today at the first of a three-day series of hearings to be held at Los Angeles.

The hearings are being held by the Assembly Public Health Committee. The first of the Statewide hearings was held at San Diego Tuesday. San Francisco hearings have been set for March 2 and 3.

Governor Warren's office announced yesterday that no official representative of the Governor would present his compulsory health insurance bill, although it was possible that one of the authors who resides in the south might appear before the committee today.

John Hunton, executive secretary, and Howard Hazard, attorney, will speak for the Northern California section of the California Medical Association, along with Dr. Lowell S. Goin, president, and Dr. Vincent Askey, both of Los Angeles. The C.M.A. is backing a voluntary health insurance plan.

Dr. T. Henshaw Kelly, secretary of the California Physicians' Service, which operates a voluntary system of prepaid medical care, issued a statement that at least \$100,000 in State taxes would be required in addition to payroll deductions to maintain any compulsory health insurance system in California.

Dr. Kelly's statement was issued through the Public Health League of California by Clem Whitaker, publicist for the group of doctors who will campaign against the Warren plan.

"The experience of the California Physicians' Service in providing complete medical and hospital care for per-

sons living in war housing projects," said Dr. Kelly, "has demonstrated that the costs of such service average from \$42 to \$50 per person per year."

He contends that the 3 per cent payroll tax provided in both Governor Warren's bill and the C.I.O. measure would be insufficient to meet the costs of a compulsory system. The payroll deductions should run between 5 to 6 per cent instead, he maintains.

Dr. Kelly states "persons now under unemployment insurance" had earnings in 1944 of about "five billion dollars, so that a 3 per cent payroll deduction tax on that amount would have yielded about \$150,000,000.

But he says the contemplated care of 6,500,000 people "even at the low figure of \$40 per person" would total \$260,000,000 a year, making necessary a contribution from the State.

Statisticians for both Governor Warren and the C.I.O. claim the average cost of medical care has run between 3 and 4 per cent per family a year.

"It is undoubtedly significant," says Dr. Kelly, "that the Warren bill contains a provision, pledging 'the faith and credit of the State . . . to assume the operations of the system until June, 1949,' and some of the other bills provide for direct State appropriations to defray the administrative costs of the program."

Provisions of the Thomas bill, sponsored by the C.I.O., will be explained today to members of the public health section of the Commonwealth Club at its weekly Hotel St. Francis luncheon seminar.

Paul Pinsky, research director of the C.I.O., will discuss the bill. . . .

Pinsky said he would explain in detail the reasons why his group favors payment of medical services by the capitation, or per capita plan, rather than on a fee basis. Special services are to be paid on a fee basis out of a State medical insurance fund.

The Governor has expressed a preference for the fee system of payments.

Pinsky said estimates of the probable income from payroll taxes are now being made by his organization.

Robert Burrill, representing the C.M.A., will speak on "Compulsory Health Insurance" before the San Francisco chapter of the Controllers' Institute tonight at a Hotel St. Francis meeting.—Earl C. Behrens in San Francisco *Chronicle*, February 15.

#### ITEM XIII

##### Health Insurance Hearing

*Opponents Charge Plan is a "Step Toward Socialism"; \$100,000,000 Deficit Predicted If Program Passes*

Los Angeles, Feb. 16.—Governor Warren's recommendation that the current Legislature enact a compulsory health insurance law was branded here today as "a step toward State Socialism" and as certain to cause an "immediate deficit of at least \$100,000,000."

Paul Shoup, head of the Los Angeles Merchant and Manufacturers Association, made the charge to the members of the Assembly Public Health Committee, that the establishment of a system of compulsory health insurance was the "crossing line from the Republican form of government to a Socialistic or Communistic State."

As one of the spokesmen for the California Medical Association, Executive Secretary John Hunton, San Francisco, said enactment of a compulsory health act covering 6,500,000 persons, as is contemplated, would cost about \$260,000,000 annually or almost \$100,000,000 more than the proposed 3 per cent payroll tax would raise to finance the system.

Hunton also declared present inadequate hospital facilities would necessitate the expenditure "of \$50,000,-

000 for improvements, etc., at existing hospitals" to take care of the people under the program.

This was opposition day at the hearing. Numerous speakers urged that further study be made before any action is taken.

Representatives of voluntary health and hospitalization programs, industry, builders, contractors, apartment house owners, as well as doctors, joined in asking for delay in the passage of any bill on the subject.

Dr. William F. Henry, speaking for the California Chiropractic Association, said his group was neither opposing nor supporting any of the bills before the Legislature. He asked that the chiropractors be included, however, if any compulsory health insurance act is passed. They are not now included in either Governor Warren's bill or that sponsored by the C.I.O.

The Los Angeles Chamber of Commerce, through Ronald M. Ketcham, declared opposition to any compulsory health plan, declaring to finance the anticipated deficit "would require that the present sales tax, for example, be tripled."

First to propose that further study be made of the problem came from Dr. E. Vincent Askey, speaker of the House of Delegates, executive body of the California Medical Association.

Dr. Askey said he spoke as a "private practitioner," who was opposed to "all of the compulsory health insurance bills" now pending before the Legislature.

Dr. Askey added spice to the hearing by charging that C.I.O. representatives, including Albee Slade, a witness yesterday, had sought to conceal from the people the cost of compulsory health insurance by providing for the payroll tax method of raising the funds to support the program.

The witness challenged statements by Slade that C.M.A. officials, conferring as individuals, had agreed upon a set of principles to be included in proposed compulsory health insurance legislation. Slade said there had been discussion at the conferences about the need for the establishment of a \$200,000,000 fund by the State to start the health insurance system. But, Mr. Askey contended, the C.I.O. representatives had insisted that if the people knew of the need for setting up such a fund, they would "turn down" any legislation on the subject.

Dr. Lowell S. Goin, president of C.M.A., who preceded Dr. Askey before the committee, told of the conferences with the C.I.O. representatives. He said "we sent out scouting parties into the enemy's country" and discussed certain phases of the health problem.

"I offered a series of principles," said Dr. Goin, in testifying as to the conferences with Slade and others. He said these principles were the "very least that would be included."

Dr. Goin said that, however, "he never had, do not now and have no intention of supporting compulsory health insurance."

He said he believed the "overwhelming number of doctors in California are opposed to compulsory health insurance."

"It is our studied opinion," declared Dr. Glen D. Cayler, director of the public affairs department of the California Osteopathic Association, "that some plan providing a prepayment insurance on a compulsory basis is the only kind of a plan that can be successful, and should be worked out in cooperation with all interest in the groups and put into effect without undue delay."

John S. Selover, representing the Christian Scientists, told the committee he did not oppose any of the health insurance bills but only asked that in any compulsory

health insurance bills protection be given "the religious liberties of the Christian Scientists."

Opposition to Governor Warren's bill was expressed by William Penn, Los Angeles chapter, National Electrical Contractors' Association, because of "the payroll tax."

David G. Shearer, representing trucking interests here; C. C. Cashwell, secretary-treasurer, Building Material Dealers' Credit Association, and Dave Smith, general counsel, Motor Car Dealers' Association, all opposed the compulsory health insurance bills because of the payroll tax, 1½ per cent of which must be paid to the employer.—Earl C. Behrens, in *San Francisco Chronicle*, February 17.

#### ITEM XIV

##### Deficit of \$100,000,000 Seen in Health Proposal

*Medical Association Official Warns of Vast Costs at Legislative Hearing*

Compulsory State health insurance, if enacted, would run into an immediate deficit of \$100,000,000 the first year, the Assembly Committee on Public Health was warned yesterday.

The deficit prediction was made by John Hunton of San Francisco, executive secretary of the California Medical Association. He based it upon figures and experience tables from privately operated group insurance plans, particularly the California Physicians' Service, which handles about 300,000 patients a year.

In that system, he said, the doctors handle about 650 calls a year per 1,000 patients. This is on the limited coverage. The moment full coverage goes in the demand would jump to about 1,300 calls a year and if the children were added it would be about 1,790 calls a year per 1,000 patients, said Hunton. This is what is proposed in compulsory health insurance.

##### Care of 6,500,000

The C.P.S. estimates full medical and hospital and surgical care at a minimum of \$40 a year a person. With 6,500,000 persons to be served in the State under the proposed compulsory plans, this would require \$260,000,000 per year in the fund.

The unemployment insurance records show \$164,000,000 a year coming in from the over-all 3 per cent unemployment insurance taxes, which is what the health insurance fund would net annually. This would leave the \$100,000,000 deficit, assuming operating costs paid by the State. After the war, when employment drops, say to the 1941 level when the 3 per cent tax netted \$80,000,000, the deficit would jump proportionately.

Ralph Walker, executive director of the Blue Cross in Southern California, said his organization, which gives insurance for hospitalization, favored the voluntary plan.

##### Doubts Readiness

There are 17,000,000 enrolled in the Blue Cross insurance plan in the country and in California about 250,000, said Walker. The enrollment is growing by 3,500,000 a year, he said. That is what the people want, he thought, protection against the heavy hospital bills in serious illness. He doubted the people are ready today to approve a law taxing themselves for health insurance. The organization experience shows that they can insure a family for their service at \$2.60 a month, said Walker. . . .

Among organizations represented in opposition to compulsory health insurance at this time were commercial printers and wholesale paper dealers, the Apartment House Association, Southern California Restaurant Association, Downtown Business Men's Association, Los Angeles Chamber of Commerce (with a full report to be made in March at Sacramento), Los Angeles Painters

and Decorators Association, Southern California Retail Grocers Association, California Hospital Association—with figures showing the hospitals could not even begin to care for the patients—the East Los Angeles Property Owners Association and others.

##### Sees Vast Costs

Earlier the committee was told that representatives in a conference with some doctors argued that if the people of the State were to be told right at the start that State compulsory health insurance would require \$200,000,000 of tax money to get it going they would turn it down promptly. Thus, the C.I.O. men were represented as suggesting, it would be better just to finance the thing gradually by a total payroll deduction tax on employers and employees of 3 per cent.

Dr. E. Vincent Askey, speaker of the House of Delegates of the California Medical Association, made the statement about the C.I.O. proposal. He appeared before the committee in his capacity of private practitioner, he said.

##### Fights State Rule

Askey said he had no objection to a voluntary system of public health insurance.

"I do oppose," he said, "the constant intervention in my affairs by the State and I object to myself and others becoming the creatures of the State rather than the State being the creature of the people."

Askey said none of the bills offers real compulsory health insurance as there is no compulsion on the individual to see a doctor or would the doctor be required to sign up for the service. A person with venereal disease, for instance, would not be required under this bill to see a doctor.

##### Predicts No Wonders

Dr. Lowell Goin, president of the California Medical Association, also warned against what to expect even if compulsory health insurance laws were passed. Germany has had such laws for 60 years and England for about 35 years, and yet their records on health as to draftees is not as good as ours, he said.

This matter of the proponents saying how such a law would eliminate the very high rejections on the draft is nonsense, he said. They talked about 5,000,000 men being rejected. The fact is that that figure is not accurate and when you take out all those who suffered mental defects, those who were cripples, natural or accidental, those with defective vision, those with venereal disease, you wind up with about 1,500,000 rejected men—and it is questionable how much public health insurance could have done for them, he asserted.

##### For Voluntary Plan

Certainly something should be done along that line and that is why, Goin said, the Medical Association is sponsoring Assembly Bill 1200 which calls for such insurance on a voluntary basis, using funds from unemployment insurance, partially, to finance it. No new taxes. Medical science has no magic wand with which to prevent and cure disease.

Other opponents to compulsory State health insurance financed by payroll deductions included David Shearer, for the Trucking Industry, Inc.; C. C. Cashwell of the Building Material Dealers Credit Association, David Smith for the Motor Car Dealers Association and Warren Penn for the Electrical Contractors Association.—*Los Angeles Times*, February 17.

#### ITEM XV

##### Health Insurance

*Fight by Warren Called the Only Way to Pass Bill*  
Los Angeles, February 18.—Unless Governor Warren

personally and vigorously enters the fight, and is able to influence both public opinion and the Legislature, there appears to be slight chance a compulsory health insurance act will be passed at the current session.

This becomes evident after public hearings by the Assembly Public Health Committee.

The committee spent three days here and one in San Diego, hearing from persons interested in health insurance. Further hearings will be held later in Fresno, San Francisco and Salinas.

#### Committee's Antagonism

It requires no occult powers to discern the antagonism of a considerable number of the Assembly Committee to any compulsory health program.

At the present writing there seem to be only three members of the committee, Assemblymen Gaffney, San Francisco; Hawkins and Massion, both of Los Angeles, who are for either Governor Warren's bill or the Thomas bill, sponsored by the C.I.O.

Two members, G.O.P. Floor Leader Collins, Fullerton, and C. Don Field, Glendale, are among the coauthors of the "voluntary" plan, fathered by the California Medical Association. Assemblymen Emlay, garageman of Salinas; Ralph C. Dills, school teacher of Compton; Chairman Fred Kraft, San Diego druggist, and Richard McColister, secretary of the Insurance Brokers' Exchange of San Francisco, gave no evidence of any friendliness toward the compulsory systems during the hearings. Assemblyman Pelletier, Los Angeles, expressed opposition to a compulsory plan. Assemblymen Debs and Evans, both of Los Angeles, and Thompson, San Jose, were counted more likely at this moment to be against than for the compulsory bills.

#### Senate Feeling

G.O.P. Floor Leader Collins was placed on the committee because of his position. He stated here he authorized the C.M.A. bill at the request of a long-time personal home-town friend.

On the Senate side there is likewise a chilly feeling on the part of many members toward compulsory health insurance.

The controversy is certain to become a battle of experts and statisticians.

From all indications, the C.M.A. group which has employed Clem Whitaker, San Francisco publicist, to handle its drive against the Governor's recommendation and the C.I.O.-A.F.L. and other proponents of compulsory health insurance, do not intend to engage in any cream-puff campaign.

The manner in which cost figures and pro and con arguments are being tossed about by both sides will have the public and the legislators dizzy.

#### C.M.A. Bill Is An Out

There is a belief among supporters of the Governor's program that the C.M.A. bill, which taps existing State unemployment insurance funds to pay certain medical costs, was dropped into the legislative hopper by the shrewd Assemblyman Collins to give many of the lawmakers an "out."

When the controversy waxes hot, the legislators can say they voted for health insurance by supporting Collins, et al bill, but at the same time can take refuge behind the fact that compulsory health insurance is still in the argumentative stage in California.

C.I.O. leaders have served notice, if no compulsory health measure is passed at this session, they will take the issue to the voters at the 1946 general election. Some skeptics insist that certain of the C.I.O. leaders care not whether the Legislature acts or not, since if it does not they will have an issue for the 1946 campaign.

But Governor Warren's future political fortunes may

also be wrapped up in early action on compulsory health insurance.

Many of the Governor's 1942 supporters in industry are against him on this issue. In the Legislature, he seems to have less important support among the Republicans than in Democratic ranks. Yet many Democrats may spike his program so as to deprive him of any credit when the gubernatorial election rolls around two years hence.

Should no compulsory health bill be passed and the C.I.O. proceed with plans to put its measure on the ballot, the Governor then would find himself in the midst of a controversy of great bitterness.

To be consistent he would have to get into the fight which in turn would involve him with many of those from whom he will expect support in his reelection campaign. This is particularly true in Southern California.—Earl C. Behrens, in *San Francisco Chronicle*, February 19.

#### ITEM XVI

##### G.O.P. Studies Health Bill Provisions

##### *Group to Give Report on Insurance Program*

Lake Arrowhead, February 19.—(AP.)—The California Republican Assembly today looked to a committee of nine to determine its stand on Statewide health insurance.

Findings of the committee will be reported to directors before the current State legislative session closes.

All resolutions on health insurance plans were tabled by the assembly's directorate in closing a three day conference yesterday. The resolutions committee had reported favorably on voluntary insurance through its chairman, Clarence Rogers of Santa Barbara, but Edgar Hurley of Alameda led a contingent of conferees supporting the program recommended by Governor Earl Warren.

#### Officers Elected

Arthur Carmichael, San Jose, was elected president, succeeding Murray M. Chotiner, Los Angeles. Other officers include:

Vice-Presidents, John S. Berry, San Bernardino; Bruce Holam, Oakland; Mrs. Edith Heger, Huntington Park; Vroman J. Dorman, San Diego; Clarence Rogers, Santa Barbara; Mrs. Page Montegale, San Francisco, and Paul Mason, Sacramento.

Glen Baker, San Mateo, secretary; Roy Crocker, South Pasadena, assistant secretary; Harding McGuire, San Francisco, treasurer; Benjamin McNeil, Glendale, assistant treasurer. . . .—*San Francisco Examiner*, February 20.

#### ITEM XVII

##### The Warren Health Plan

##### *Governor to Make Public Campaign for His Medical Bill*

Governor Warren yesterday announced he would carry his fight for adoption by the Legislature of his compulsory health insurance program directly to the people in a series of radio talks and a limited number of public addresses.

The Governor will make his first radio address over the Blue network, 9 p.m. tomorrow night, he said yesterday.

Because of wartime travel restrictions, the Governor said his public appearance would be made at key cities in the State.

Warren also will discuss various parts of his legislative program in later broadcasts.

The Governor answered a prepared statement issued by the California Medical Association that enactment of a compulsory health insurance act would, in effect, place California medicine in the hands of the politicians.

"Unfortunately," he said, "whenever anyone tries to do something for the public at large, the cry of politics is raised.

"There will be no attempt, so far as I am concerned, to dictate the terms on which we may have health insurance.

"The Legislature can write any safeguards it desires around the system, both to protect the professional standing of doctors and to protect the fund from any kind of mismanagement.

"I believe the Legislature is capable of doing that kind of a job if it gets the cooperation of doctors, employers and employees, all of whom have a right to participate in the program."

The Governor challenged the statements of the opponents of compulsory health insurance that his health insurance plan would require the State to provide \$100,000,000 annually to finance it.

"If the people could not afford to have such care under a plan like this, where employers and employees share the costs, then they certainly could not afford to pay for such services through the purchase of voluntary health insurance," he declared.

From Dr. Lowell S. Goin, president, and Dr. Philip K. Gilman, president-elect, came the statement which the Governor answered. The two C.M.A. heads said they would do everything "in our power to keep the hands of politicians from controlling the practice of medicine in California."

They said "a campaign of education will be conducted to awaken people to the menace of political control of medicine, and to encourage and facilitate the extension of voluntary programs for prepaid medical care."

Drs. Goin and Gilman said there will be "no compromise, so far as the California Medical Association is concerned, on the issue of compulsory health insurance."

They said the whole program was "another dangerous step toward regimentation."—San Francisco *Chronicle*, January 20.

#### ITEM XVIII Health Program

What goes on at Sacramento is not, as it may at first glance appear to be, a debate which will decide whether there shall be a public health insurance program. If the Social Security administration is any criterion, the present issue is whether we shall have a sound health insurance system established by the people of California for their needs, or wait and get one handed to us by politicians for political purposes.

There was the same kind of pressure for some kind of social security that there is now for public health insurance. The very men and interests best fitted to establish a social security program, if one was to be established, resisted or neglected the opportunity.

The consequence is the present social security administration, in which social security is secondary and politics is the first and more or less constant issue. More talk and brain power is used now to resist the politics than would have provided a sounder program with better security than the present one gives.

The proponents and opponents in the health insurance controversy at Sacramento represent ability that can write a program very much more acceptable to the people of California than a plague of bureaucrats will be.—Editorial in San Francisco *Chronicle*, February 20.

#### ITEM XIX Huge Deficit in Health Plan Predicted by State Chamber

Deficits of from \$88,000,000 to \$204,000,000 a year would be created under any of the compulsory health in-

surance proposals now before the Legislature, according to a factual report released yesterday by the California State Chamber of Commerce.

Harrison S. Robinson, president of the State chamber, said no policy has been arrived at by the organization concerning the subject of prepaid medical care as a whole, but that a decision will be made later after further study and investigation by committees and the board of directors.

Neither the plans advocated by Governor Earl Warren nor by any other group, could operate without incurring a heavy deficit, the report asserts. It estimates the actual cost per year of the proposed health services as "somewhere between \$298,000,000 and \$415,000,000."

Other highlights from the State chamber's study include:

1. There is a direct relation between sickness and ability to pay for medical care, with illness increasing as the income level drops.

2. Eighty per cent of California employers provide paid sick leave for their salaried employees.

3. More than 1,500,000 Californians are in various existing voluntary and group programs.

4. California employers now pay about 8 per cent of their total payrolls on workmen's compensation, old age and unemployment insurance. The prepaid medical care plan would add another 1½ per cent, increasing the differential which California employers must surmount in competing with employers in other States.—San Francisco *Examiner*, February 22.

#### ITEM XX Warren Takes Health Fight to Taxpayers

*He Broadcasts New Appeal for Prepaid Medical Care*

Governor Earl Warren carried his fight for compulsory health insurance directly to the people of California last night, urging in a Statewide broadcast from San Francisco that a system of prepaid medical care be set up by the 1945 Legislature, and leaving the door open for compromise on detail.

Warren said he was not surprised at the opposition which the program had aroused, and declared he was comforted by the fact that the opposition "has not, and I believe will not, attempt to argue that the people of our State are receiving or have received adequate medical care.

"All of us," he added, "shudder when we hear stories of what the cost of illness has done to a friend or neighbor. Individually we cannot help them. Collectively we can, and that is what I am proposing."

#### Urges Full Trial

He added:

"I have no pride of authorship in regard to the details of the bill which I have had submitted to the Legislature. It has been my hope from the outset that the proposal would be thoroughly discussed and debated. No one has all the answers as to how such a program would work in California for it has never been tried here. . . ."

The Governor took no formal notice of the caustic criticism of spokesmen for the California Medical Association in opposing compulsory health insurance. He did, however, reply point by point to the doctors' accusations that he proposed "State medicine."

"Public health has always been considered the responsibility of community and State, and I want to see it remain so," Warren said. "It can only remain so if the State actually accepts the responsibility and solves the problem that confronts us.

#### Freedom of Choice

"I want to see a program adopted which preserves the existing freedom of choice between patient and doctor.

I do not want to see doctors in the employ of the State. I want to see them paid for their services from a fund that is ample, both to provide the necessary medical care for the patient and reasonable compensation for the doctor.

"I want to see the people pay for what they get and I want to see the control of the program close to the people."

Private health insurance programs now available, Warren said, are not easy to enter, are not universal in application nor all-inclusive in coverage, and "cannot truthfully be said to be adequate for all the people so far as medical care, laboratory tests and hospitalization are concerned."

#### Doubts System

Of the California Physicians' Service, the Governor commented:

"I believe it is open to serious question whether any program which in six years has attracted the voluntary participation of only 100,000 people out of a population of 8,500,000, will ever be able to fill the public need."

The California Medical Association announced last night through John Hunton, its executive secretary, that it will reply to Governor Warren Friday night, speaking over the same stations. Warren will make his second address next Wednesday night, with the C.M.A. replying again on the following Friday.—(Ed. Note. For reply, see in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 108.—R. W. Jimerson, in San Francisco *Examiner*, February 22.

#### ITEM XXI Health Insurance

##### *Warren Carries Health Plan Fight to People Over Radio*

Governor Warren last night personally carried his proposal for a California program of compulsory health insurance directly to the people.

"In asking the Legislature to create a prepaid health insurance program as a means of improving the general health of our people," the Governor said, "I gave emphasis to my belief that such an effort is a State responsibility."

Warren spoke over the Blue Network in the first of a series of radio addresses in answer to the campaign aimed against his health insurance recommendation to the legislators by the California Medical Association and other organizations.

He declared that the citizens who had been "shocked" at his proposal "were not the millions who so badly need such a system to bring happiness and comfort into their homes." Neither, he said, were they the people "in our State who have pioneered the way in industrial accident compensation, unemployment insurance, aid to the aged and aid to the blind."

#### On Public Conscience

The Governor said "facts assembled during more than 30 years of study in California are being reanalyzed" and asserted "study and research have begun to cause the problem to weigh upon the public conscience." Time for action has now arrived, the Governor said.

Warren emphasized the fact he did not "want to see doctors in the employ of the State" or did he want to see the present relationship between doctor and patient disturbed.

Warren stressed the need among those in the lower income brackets for the establishment of a prepaid medical care program.

He said the voluntary health programs had failed to reach a sufficiently large number of the population. Warren praised those employers who had set up systems of caring for the health of their workers.

"Out of the millions of people in need of medical

care," said the Governor, "there are hundreds of thousands each day of the year who are going about their work only partially capable of doing their job. They cost the employer real money. Proper medical attention could return them speedily to a status of efficiency."

"Individually," Warren declared, "we cannot help them. Collectively, we can, and that is what I am proposing."

Warren said he had "no pride of authorship" in the bill he had submitted to the Legislature, but he believed it was the one "sufficiently flexible in structure so that it can be quickly improved when experience has pointed the way."

He said the bill would not put his plan into full operation until January, 1947, "and even then the inauguration of it can be postponed if the war has not ended."

Coincidental with the Governor's first address, announcement was made that the C.M.A., at the invitation of the Blue network, would also go on the air to present its opposition to Warren's recommendation.

Stanley Cochems, executive secretary, Los Angeles County Medical Association, will make the first broadcast for the doctors, opposing compulsory health insurance, tomorrow night, at 9:45. Dr. Lowell S. Goin, president of C.M.A., will broadcast on March 2.—Earl C. Behrens, in San Francisco *Chronicle*, February 22.

#### ITEM XXII

##### **Health Insurance to be Forum Subject**

A panel of speakers will hold a public forum on "health insurance legislation" at 2:30 p.m., Sunday, in the auditorium of the High School of Commerce, Van Ness Avenue and Hayes Street. The meeting is open to principals, teachers and others interested, and those attending may participate in an open discussion following the panel, Board of Education officials said.

Points of conflict in the pending health insurance legislation will be discussed by Bernard Berkov, member of the professional advisory committee of the Northern California union health committee; Robert Kenny, attorney general of California; Dr. Alson R. Kilgore, member of the California Medical Association, and Dr. Samuel May, of the University of California school of public administration. Professor Max Radin of the University of California will be moderator.—San Francisco *Call-Bulletin*, February 23.

#### ITEM XXIII

##### **Health Insurance Battle—Round Two**

##### *Medical Association Objects to the Cost*

The second round in the air lanes battle between Governor Warren and the California Medical Association over the compulsory health insurance issue was fought out last night.

Stanley Cochems, executive secretary of the Los Angeles County Medical Association, speaking for the C.M.A., declared in a Statewide radio broadcast over the Blue network that enactment by the Legislature of a compulsory health insurance act would result in millions of dollars in new taxes and would not improve public health.

Governor Warren opened the radio debate Wednesday night and will return for another round in the fight next Wednesday night over the Blue network.

Cochems predicted that payroll deductions would be insufficient to meet costs of compulsory health insurance, as provided in pending legislation, and that the additional sums necessary to pay hospital and doctors' costs would require doubling the State sales tax, or a State levy on real property, or new taxes on every form of business.

The speaker said both Governor Warren's bill and that sponsored by the C.I.O. have been declared to be "outrageously impractical" by men trained in tax matters.

Cochens estimated that the cost of compulsory health insurance for an estimated 6,500,000 persons would be \$250,000,000 a year, based on experience of the California Physicians' Service, which shows \$40 per person annually to be the minimum cost of medical care.

He declared that the proposed 3 per cent payroll tax would have raised only \$160,000,000 "in the peak year of employment, 1944, leaving an annual deficit of \$100,000,000 for the State to pay out of its general fund."

He said the bill for health insurance might run as high as "\$520,000,000 a year in California."

Cochens declared that the medical services provided in the compulsory health bills "are not available now and will not be available for years to come."

He said there was a shortage of doctors now and that the doctors could not render additional services.

The speaker declared that compulsory health insurance "would not have changed" the situation relative to draft rejections. He declared England with compulsory health insurance for 30 years had a much higher percentage of rejections for physical and mental reasons, than the United States.

"Study of prepaid health insurance in practice, not theorizing, is needed before plunging California into a morass of debt," said the speaker. He contended the "3,000 California doctors in military service" should have a voice in the final decision on health insurance, which he declared was not a matter of urgency "at this time." —Earl C. Behrens, in *San Francisco Chronicle*, February 24.

#### ITEM XXIV

##### Pros, Cons of Health Plan Told at Forum

Pros and cons of health insurance, compulsory vs. voluntary, were discussed yesterday afternoon in an open forum at the auditorium of the High School of Commerce.

Dr. Alson R. Kilgore, speaking for the California Medical Association's voluntary health proposal was opposed by three principal and several secondary speakers who urged adoption by the Legislature of a compulsory health insurance act.

Professor Samuel May, University of California School of Public Administration, reviewed the history of the 30 years of study of the health insurance subject in California.

##### Costs Too High

He declared surveys had shown that one-third of the people in the United States were unable to maintain medical and hospital services for themselves because of the costs.

"Nowhere," said Professor May, "has the voluntary plan even scratched the surface." He said the California Physicians' Service, a voluntary plan, had only been able to reach something over 100,000 people out of the 8,000,000 in California. He urged approval of a compulsory health bill.

Dr. Kilgore said the C.M.A. recognized the need for adoption of a plan for a better distribution of the costs of medical care, but "we object to seeing the care of the sick placed under political control." He declared the C.M.A. voluntary bill proposed that workers be permitted to use a part of their future unemployment payments for sick benefits.

Dr. Kilgore urged that no action be taken upon compulsory health insurance "until the 3,000 doctors in the service and the 800,000 Californians in the armed forces return home and have an opportunity to express themselves."

##### Tax Insufficient

He said the programs as provided in both Governor Warren's bill and that sponsored by the C.I.O. would

cost more than the amount which the 3 per cent pay roll tax would raise.

Dr. Kilgore said there was \$630,000,000 in the State's unemployment fund. "We propose," he declared, "no tapping of that fund, but we propose that in the future a part of the employees' tax be remitted."

Attorney General Kenny, who advocated compulsory health insurance and payment of doctors by the capitation, or set sum per person per year plan, analyzed the four principal health insurance measures now pending before the Legislature. These included Governor Warren's, the C.I.O. measure, the California Farm Bureau proposals and the C.M.A., or "doctors' bill."

Kenny expressed the belief that the doctors' bill "would deplete the State's unemployment fund." . . . —Earl C. Behrens, in *San Francisco Chronicle*, February 26.

#### ITEM XXV

##### State Must Control

Illustrative of the progress in public thinking made by the idea of public health insurance is a recent statement of the social security committee of the Life Insurance Association of America. It says government experiments with public health insurance should begin at the local or State levels, not at the Federal level.

Time was, and not too distantly in the past either, that life insurance authorities were intolerant of public health insurance on any level. They were just against it *per se*. This indication that they would be willing now to have it tried experimentally on local and State levels is a decided liberalization of attitude.

With the committee's conclusion we decidedly agree. We believe the machinery of administration of whatever plan is adopted should be under State management instead of under national bureaucratic control too remote from the beneficiaries to be easily modified in case of need. An important requirement is that the plan be flexible enough, at least in the experimental stages, to permit of changes the moment any details prove unworkable.

That does not kiss the Federal Government out of the picture entirely. It may be some measure of its participation may be worked out similar to the unemployment insurance arrangement. But still, the control and operation should be in State hands.—*San Francisco News*, February 26.

#### ITEM XXVI

##### Health Program

##### Voluntary Insurance Plan is Urged by Farm Bureau Representative

Establishment of voluntary rather than compulsory health insurance program in California was urged yesterday in a Hotel St. Francis luncheon talk by Von T. Ellsworth, representative of the California Farm Bureau Federation.

Ellsworth opposed both the proposals of Governor Warren and the C.I.O.'s, and other compulsory health insurance bills now pending before the Legislature.

Addressing a group which included doctors, dentists, and representatives of business and industry, Ellsworth asked support for two measures introduced in the Legislature by Senators George J. Hatfield, Merced County; Bradford S. Crittenden, San Joaquin County, and Louis G. Sutton, Colusa County. The Farm Bureau Federation is sponsoring the bills.

Ellsworth said there seemed to be general agreement that health facilities and services are inadequate and that they are unevenly divided. Furthermore, he said, the ruinous aspect of unexpected large doctor and hos-

pital bills can be avoided through health insurance methods.

#### Health Association

One of the bills sponsored by the Farm Bureau group would encourage the formation of associations of doctors or of laymen to make health service available to those who want to buy it.

The second of the measures would make tax-supported county hospitals available on a cost and ability to pay basis for those who choose to use them, those who have peculiar diseases which can best be treated there and to those who cannot afford the private health service under the voluntary association plan.

Although admitting that until present statutes are changed the proposed compulsory health insurance coverage would not apply to the farmers, since neither they nor their laborers are subject to unemployment insurance, Ellsworth objected to the compulsory plan on the ground it was regimentation.

Senate bill No. 218, first of the Farm Bureau Federation bills, declares the purpose of the act is "to empower county boards of Supervisors to authorize the use of a county hospital by all the residents of the county and to charge the costs so incurred to each individual using such facilities in accordance with his ability to pay such costs."

Ellsworth said adoption of this proposal "will necessitate the construction of some Government hospitals."

The other bill would require all health associations to be licensed by the State Department of Public Health, which is its administrative body. It would direct the department to issue a license upon the approval of a contract, if it is convinced the provisions of the contract can be fulfilled, and upon receipt of \$25 as a filing fee. The State Health Department would require necessary medical reports and the performance of a high standard of medical service. The act also provides for the incorporation of doctors or laymen to provide health service.

Ellsworth contended the voluntary program of his organization would provide "the long-needed law legalizing periodic payment plans which will encourage doctors to engage in this form of practice."—Earl C. Behrens in *San Francisco Chronicle*, February 9.

#### ITEM XXVII

##### Northern G.O.P. Refuses Okeh of Health Bill Section of State Central Committee Declines Also

Republicans of the State Central Committee, Northern section, late yesterday tabled a proposal to indorse the broad principles of Governor Warren's legislative program and rejected every effort to array a policy or take a stand on state affairs. . . .

Chester MacPhee, San Francisco supervisor, made a strong plea for some overall indorsement of Governor Warren's program, as a liberal and farsighted approach his party should support. He acknowledged he is not in sympathy with every Warren idea (especially taxes) but said the direction is right.

"We ought to try to raise standards of the Republican Party to the level of the plain working man," he declared. "Until we gain confidence from plain Mr. Jones, we Republicans won't gain votes."

In lively discussion that followed, the motion was tabled and Governor Warren cold-shouldered. . . .—*San Francisco News*, February 28.

#### ITEM XXVIII

##### Forum Favors Compulsory, Not Voluntary Health Plan

A poll taken at last Sunday's, February 25th, public

forum on health insurance showed 84.2 per cent of the 272 persons who voted favored the compulsory system, as against 14.3 per cent who favored voluntary insurance, with 1.5 per cent of those voting opposed to any system. The forum was held at the High School of Commerce of San Francisco. The poll was taken by the Northern California Union Health Committee which sponsored the forum in conjunction with other groups.

On the question of payments for operation of a health system, 264 persons in attendance at the meeting voted. Of this number, 82.5 per cent favored an equal employee-employer payroll deduction; 5.3 per cent voted for deductions by employees only and 9.4 per cent were opposed to any employee deductions.

Control of the administration of a health insurance act by a public body with professional advice was favored by 90.6 per cent, while 9.4 per cent wanted the administration to be in the hands of the medical professional only. The capitation, or set sum per person per year, plan of paying doctors was favored by 78.7 per cent, as against 21.2 per cent who voted for the fee-for-service, or fee for each service rendered.—*San Francisco Chronicle*, March 1.

#### ITEM XXIX

##### Nurses Association Ask Health Plan

The California State Nurses Association wants nursing included in any State health insurance program and will seek a hearing before meetings of the Assembly public health committee in San Francisco on March 2, Miss Shirley C. Titus, executive director of the organization, announced yesterday.

"We believe that nursing services should be provided for under any health insurance plan when these services are deemed necessary by the physician in charge," Miss Titus said. "We are prepared to offer an amendment to any health insurance bill coming before the Legislature, making provisions to this effect."

The nursing profession should also have a place on the board of the proposed Health Service Authority, or on the executive body of any other approved system, Miss Titus added.—*San Francisco Examiner*, March 1.

#### ITEM XXX

##### Legislators Clash at Fresno Health Insurance Hearing

Fresno, Feb. 28.—(AP).—Controversy over the 13 different health insurance bills now before the State Legislature flared into a row here today between various members of the Assembly's Interim Committee on public health over a purported analysis of the principal measures being read before a public hearing by Chairman Fred Kraft of San Diego.

Assemblymen Edward Gaffney, San Francisco, co-author of Governor Warren's original bill, and Jack Massion, Los Angeles, author of another of the bills, interrupted Kraft's reading with charges the analysis gave the Fresno audience a wrong and biased impression of the content and effect of some of the measures.

"Are you reading an argument against the bills or an analysis?" Gaffney demanded. "You are building up the California Medical Association plan and tearing down the Governor's bill."

Kraft replied he was reading an analysis of the principal bills at the request of numerous people in the audience and the analysis, which was prepared by the Medical Association, was the best material at hand.

"Because the State Chamber of Commerce said so," Gaffney interjected.

Vice Chairman Ernest Debs of Los Angeles demanded order and requested Gaffney and Massion to allow Kraft to continue.

Gaffney's original interruption was made after Kraft read from the Medical group's analysis that the 3 per cent pay roll tax proposed by Warren would fall short by more than \$100,000,000 of paying the cost of the program.—San Francisco *Chronicle*, March 1.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### Legislative Bulletin

THE PUBLIC HEALTH LEAGUE OF CALIFORNIA  
Hotel Sacramento  
Sacramento, California

The Legislature recessed late Saturday night, January 27th, after a 19-day session which saw 3,358 bills introduced. The sessions were resumed on March 5th.

During the closing hours of Saturday hundreds of bills were poured into the hopper and it is impossible to know at this time just what all of them contain. War time conditions in the State printing office have slowed down production, so that, at this writing, only about one-half of the bills are in print.

### Health Insurance

Health Insurance has been the Number One topic of discussion in Sacramento. Many newspaper writers predict that it will spotlight the present session. In his message to the opening session of the Legislature, Governor Warren urged enactment of a Health Insurance Plan. This was implemented with the introduction of bills in the Assembly and Senate, prepared at his suggestion.

Other bills have also made their appearance and, to date, we have found 14 that touch upon this subject or are closely related to it.

These are:

Senate Bill 218 (By Hatfield, Crittenden and Sutton) relating to admission to county hospitals and medical care at county expense.

Senate Bill 219 (By Hatfield and Sutton) authorizing and governing the practice of group medicine.

Assembly Bills 1110 and 1111 (By Stephenson and Lowery) companion bills to the above.

Senate Bill 500 (By Salsman, Shelley and Dillinger) Governor Warren's Compulsory Health Insurance Plan.

Senate Bill 699 (By Carter) relating to County Hospitals and admission of pay patients thereto.

\*Assembly Bill 449 (By Thomas, Dekker, Anderson, Massion, Fletcher, Hawkins, Kilpatrick and Rosenthal.) (This is the CIO bill for Compulsory Health Insurance.)

\*Assembly Bill 800 (By Wollenberg, Fourn, J. C. Lyons, Doyle, Brown, Dunn, Fletcher, Gaffney and Waters). (This is Governor Warren's Compulsory Health Insurance Bill.)

\*Assembly Bill 1200 (By Sam L. Collins, Field, Werdell, Erwin, Knight, Stewart, Stream and Watson.) (This is the CMA bill for the encouragement of voluntary medical, surgical and hospital plans.)

Assembly Bill 1414 (By Rosenthal) Duplicate of the Olson bill of 1939.

Assembly Bill 1525 (By Massion and Dunn) providing for a comprehensive health service to the people of California.

Assembly Bills 1595 and 1596 (By Wollenberg, J. C. Lyons and Fourn) making the necessary appropriation for Governor Warren's Health Insurance Plan.

Digests of all of the above bills are now being made and should be available at an early date.

The Assembly Bills relating to Health Insurance have been referred to the Committee on Public Health, which comprises the following members:

### ASSEMBLY COMMITTEE ON PUBLIC HEALTH

Chairman—Fred H. Kraft, Pharmacist, P. O. Box "C," Ocean Beach Sta., San Diego.

Vice-Chairman—Ernest E. Debs, Tax Statistician, 1633 Lyman Place, Los Angeles.

Sam L. Collins, Attorney, N. Cypress Ave., Fullerton.

Ralph C. Dills, Teacher, 1505 N. Spring St., Compton.

Fred Emlay, Manager, 812 Pajaro St., Salinas.

John W. Evans, Accountant, 3745 S. Grand Ave., Los Angeles.

C. Don Field, Trucking Contractor, 1552 Ridgeway Dr., Glendale.

Edward M. Gaffney, Insurance, 295 Sanchez St., San Francisco.

Augustus F. Hawkins, Business, 220 E. 46th St., Los Angeles.

Jack Massion, Druggist, 846 E. 77th St., Los Angeles.

Richard H. McCollister, Insurance Broker, 321 Sycamore Ave., Mill Valley.

John B. Pelletier, Research, 248 S. Olive St., Los Angeles.

John F. Thompson, Farmer, Rt. 3, Box 408, San Jose.

(During the Legislative Session the address of each of the above is State Capitol, Assembly Chamber, Sacramento.)

### SENATE COMMITTEE ON GOVERNMENT EFFICIENCY

The Senate Bills relating to this subject have been referred to the Committee on Governmental Efficiency, which comprises the following members:

Chairman—Ralph E. Swing, Attorney, 313 Central Building, San Bernardino.

Vice-Chairman—Harold J. Powers, Rancher, Eagleville.

Hugh M. Burns, Funeral Director, 2055 San Joaquin, Fresno.

Randolph Collier, Title Business, Yreka.

T. H. DeLap, Attorney, American Trust Building, Richmond.

George J. Hatfield, Farmer, P. O. Box C, Newman.

Thomas F. Keating, Attorney, Freitas Building, San Rafael.

Thomas McCormack, Rancher, Rio Vista

Harry L. Parkman, Wholesale and Jobber, 8 Corte Dorado, Millbrae.

W. P. Rich, Attorney, Marysville.

Jerrold L. Seawell, Insurance, 308 Mariposa Ave., Roseville.

(During the Legislative Session the address of each of the above is Senate Chamber, State Capitol, Sacramento.)

*The C.M.A. is definitely opposing Assembly Bills 449 and 800, and solidly favoring Assembly Bill 1200. (Bills starred in the list.)*

### MEDICINE

The State Board of Medical Examiners has introduced no bills in the present session of the Legislature.

In addition to Assembly Bill 1200 (mentioned above), the CMA has sponsored a bill empowering the Industrial Accident Commission to adopt rules and regulations governing medical and surgical service and a schedule fixing the reasonable value of such services rendered to employees. Assemblyman King of Oroville is the author of this bill.

### DENTISTRY

Organized Dentistry has sponsored two bills—

Assembly Bill 1597 (By Wollenberg and Kraft) mak-

ing an appropriation to the State Department of Public Health for establishment of a Division of Dental Health.

Assembly Bill 1598 (By Wollenberg and Kraft) relating to Division of Dental Health in the Department of Public Health.

### Shift in Security Strategy

The Wagner-Murray-Dingell bills now pending in Congress, which would provide everything in social security "including the kitchen sink," will be split into four or five separate proposals replacing the omnibus measure, according to American Federation of Labor spokesmen who recently wound up their annual convention in New Orleans.

The AFL has been carrying the ball in this field of social legislation, with support from the rival CIO.

Under the projected plan, which is yet to be cleared with the congressmen who have the last say, extension of old age and survivors' insurance to "the missing 20 million" would be put up to Congress in a bill distinct from others dealing with such controversial questions in as so-called "socialized medicine" and federalization of state employment insurance systems.

The AFL men have noted that the complete Wagner-Murray-Dingell bills have been resting in congressional committees for a year and a half, without even hearings. They appear to realize the truth of what congressional observers have been telling them—that it would be easier to get favorable action on the popular parts of the propositions by divorcing them from the proposals which aroused strong group opposition.

Foremost in the popular class is the proposal to give social security cards to the 20 million workers who were left out by Congress in the original law. They include agricultural workers, the self-employed, and employees of state and local governments not now covered by public pension plans.

## COMMITTEE ON SCIENTIFIC WORK

Subject: 1945 Annual Session

Memorandum—February 16, 1945

The requirements of the Federal Office of Defense Transportation are as follows:

(1) Any convention or meeting must be less than 50 persons who would require public transportation, etc., in order to accomplish three things:

1. Avoid the use of public transportation, such as railroads.
2. Prevent crowding hotels with overnight guests.
3. Prevent throwing extra manpower work upon hotel managements, through extra care of meeting rooms.

In order to accomplish the above ends, the California Medical Association which hopes to hold its 74th Annual Session in Los Angeles on Sunday-Monday, May 6-7, 1945, is proceeding as follows:

I. The only official delegates from Northern California, for whom the California Medical Association will be responsible, will be General Officers and Delegates of component county societies, not to exceed the number of 46.

II. Meetings of the California Medical Association will be held, not in hotels, but in the Elks Temple and the headquarters of the Los Angeles County Medical Association, thus avoiding hotel service.

III. The Scientific programs will be carried through, but with Los Angeles members in charge of the meetings.

In addition, C.M.A. members who are not resident in Los Angeles, will be permitted to have their papers read

"by title," thus allowing the articles to be eligible for publication in the Official Journal, CALIFORNIA AND WESTERN MEDICINE.

Or, such non-Los Angeles resident C.M.A. member may ask some Los Angeles member to read his paper, through mutual arrangement that may be satisfactory to the Section Officers.

IV. C.M.A. members who may be on the programs of the Scientific Sections and who do not live in the City of Los Angeles, will be requested to motor into Los Angeles for Sunday morning or afternoon, or Monday morning or afternoon, in order to avoid the use of public transportation.

V. C.M.A. Committee on Scientific Work hopes to secure military colleagues stationed in hospital stations of Army camps near Los Angeles to present papers. Such military colleagues can motor back to their stations on same day, thus avoiding overnight accommodations in hotels. (See also comment on page 106.)

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

U. S. Losses 536,950\*

Army Figure 461,058; Navy 75,892

Casualties for the armed forces have reached 536,950. From Pearl Harbor through November 15. Army casualties amounted to 461,058, Secretary of War Stimson said on November 30.

This was an increase of 6,878 in one week from November 7.

Navy casualties are 75,892, an increase of 1,277 for the week.

Here are the Army casualties, together with those a week ago: Killed, 89,840 and 88,245; wounded 258,106 and 254,283; missing 57,514 and 56,442; prisoners 55,598 and 55,210.

The Navy casualties: Killed 29,480 and 29,208; wounded 32,600 and 31,574; missing 9,326 and 9,347; prisoners 4,486 and 4,486 (unchanged).

The War Department made public these Army casualties for each theater from the start of the war through the end of October.

Killed	Missing	ASIATIC			Total
		Wounded	Prisoners		
1,122	921	1,603	159		3,805
CENTRAL PACIFIC					
2,344	622	5,273	10		8,249
EUROPEAN					
45,316	28,500	136,642	25,277		235,735
MIDDLE EAST					
823	1,886	639	1,693		5,041
NORTH AFRICA					
25,876	5,564	79,216	13,376		124,032
NORTH AMERICAN					
1,305	52	1,052	...		2,409
*PHILIPPINES					
1,101	14,933	1,690	12,892		30,616
SOUTH PACIFIC					
2,504	504	7,278	8		10,294
SOUTHWEST PACIFIC					
4,420	2,029	9,661	1,065		17,175
GRAND TOTAL					
84,311	55,011	243,054	54,480		437,356

\* Does not include casualties from the present Philippine campaign.

### Production, Casualties Totals Cited By British White Paper

The colossal measure of Britain's war effort was re-

\* Owing to lack of space, this item was crowded out of previous issues. U. S. casualties on February 2, 1945, reached total of 737,342. See February CALIFORNIA AND WESTERN MEDICINE, on page 96.)

vealed in London for the first time on November 28 in a Government white paper showing the British Isles alone produced 102,000 planes and 25,000 tanks and suffered almost 700,000 civilian and military casualties in the first five years of World War II.

The official report showed Britain's war spending has reached the astronomical height of \$634 a second, and the proportion of her population mobilized for war is perhaps greater than that of any other belligerent power.

Other statistics, revealed now because the war has progressed to the point where absolute secrecy is no longer essential, included:

1. Britain's armed forces now number 4,500,000 men and 500,000 women out of a total population of about 47 million.

2. More than one-third of all men in the United Kingdom between the ages of 14 and 64 are under arms, and almost half the women between 14 and 59 are in the armed forces, full-time civil defense or industry.

3. By the close of 1943 Britain had lost 11,500,000 tons of shipping, two-thirds of the tonnage with which she entered the war.

4. Casualties in the armed forces of Great Britain alone numbered 563,000 by the end of last September, including 176,000 killed; for the rest of the Empire, casualties totaled 363,000, including 67,000 killed.

5. One out of every three houses in Britain has been destroyed or damaged in air raids or by robot bombs, and civilian casualties up to the end of August numbered 57,298 killed and 78,818 injured.

6. Another 29,629 British merchant seamen were killed by enemy action and 4,173 interned by the enemy since the start of the war. . . .

#### More Military Hospitals

Army will soon be ready with extensive program of convalescent hospitals for wounded overseas veterans. Main objective is to provide accommodations for thousands of long-time convalescents who are able to walk and exercise.

Anticipating a steady increase in casualties from overseas, Army is trying to provide a maximum of bed space in its general hospitals which are equipped for most advanced types of medical and surgical attention. It's already beginning to move out of its general hospitals men who are able to be around, who do not need constant medical or surgical attention.

Question: Will Army and Navy continue to operate all the hospitals built for them, after the war? Or will they be turned over to the Veterans' Administration? And, as the number of hospitalized men decreases, which hospitals will be turned back to civilian uses and which will the Government keep?—"Washington Calling" in San Francisco News, December 2.

#### U. S. Prisoners

The House Military Committee reported recently that American prisoners of Germany are, in the main, humanely treated.

It said prisoners in Japan proper seem to be faring better than those in Japanese-occupied territories.

And Axis prisoners in the United States, it said, are well treated but not pampered. . . .

At the time the investigation was completed, in December, the committee said, there were 281,344 German, 51,032 Italian and 2,242 Japanese war prisoners in 132 base camps and 334 branch camps. . . .

"On the whole," the report said, the camps in Japan, China and Manchuria, in which an estimated 6,296 Americans are held, "seem to be more humanely administered" than those in distant Japanese-occupied territories in which there are approximately 9,865 Americans.

The committee said Swiss representatives confirmed

reports that the food given prisoners in Japanese camps is superior to that available to Japanese civilians.—San Francisco Chronicle.

#### Medical Department Trains Medical Administrative Corps Officers as Battalion Surgeon Assistants

In order to relieve the critical shortage of doctors, the Medical Department has recently increased its quota for admission to officer candidate schools and has initiated a new program of training graduate administrative officers as battalion surgeon assistants. Between now and April, 1945, appointments will be made in the Medical Administrative Corps after seventeen weeks training at Camp Barkeley, Texas and Carlisle Barracks, Pennsylvania.

From among these graduates, officers with appropriate backgrounds will be selected to receive six weeks additional training at Camp Barkeley for duty assisting battalion surgeons. The special training consists principally of advanced first aid which will qualify these officers to relieve battalion surgeons of details and thus permit the surgeons' time for purely medical and surgical work.

#### Redbook Edition of "The Army Nurse" Available

The history of military nursing is told in an illustrated 32-page special "Redbook" edition of *The Army Nurse*, just off the press. Starting with the unrecorded past, the story of nursing is traced from earliest traditions to the birth of military nursing, and through the history of American military nursing to the work of the present U. S. Army Nurse Corps. Illustrations range from reproductions of old art to photographs from Civil War times on. The "Redbook" edition, which has been published as an aid in the procurement program of Army nurses, is available to anyone who requests it from the Nursing Branch, Technical Information Division, Office of The Surgeon General, 1818 H Street N. W., Washington 25, D. C.

### C.M.A. CANCER COMMISSION

#### Health Maintenance and Cancer Prevention Clinics\*

Cancer Detection or Prevention Clinics are growing so rapidly that a review of their brief history is timely.

The first clinic was started at the Woman's Medical College of Pa. in 1937. Its purpose was to make pelvic and breast examination on 1,000 women semi-annually for five years. Correction of chronic local irritation was advised. If after five years a decrease in the incidence of cancer in these organs, or the favorable prognosis because of early diagnosis and treatment of cancer was noted, expansion of these clinics was indicated. In 1944, 1,317 patients had been seen. Eleven cancers diagnosed, ten without symptoms, one carcinoma of the breast developed four months after the last examination, which was negative, and had axillary metastases when promptly operated on. All cancer patients are well in 1944, two to five years after diagnosis. About five cancer

\* This contribution is one of several articles which will appear in CALIFORNIA AND WESTERN MEDICINE, under the sponsorship of the Cancer Commission of the California Medical Association with the hope that they will elicit greater interest in the problems of cancer and in coordinated efforts at their solution.—Isabella H. Perry, M.D.

deaths would have been expected from this age group. Four hundred forty-two pre-cancerous conditions were found. On the whole, coöperation in following corrective advice was good. In 1937 the New York Infirmary for Women and Children set up a Cancer Prevention Clinic for women. This clinic gave a complete physical examination. Special examinations were ordered at the discretion of the examining physician. This clinic was so successful that in 1940 a similar clinic was opened at the Memorial Hospital in New York. In 1944 the two clinics had examined 1,800 patients, finding 7.9 per cent with cancer. *The majority of the cases were early.* Four cancers and 50 benign tumors were found in 263 patients without symptoms.

On the basis of the results obtained in these pioneer clinics, the American Cancer Society, the International Cancer Research Foundation and the Veterans Administration are now supporting the establishment of such clinics. It is desirable that the above stated organizations agree on minimum standards for clarity and unity of purpose, and to avoid overlapping of effort.

The first clinics were in recognized hospitals, staffed by doctors experienced in cancer diagnosis. Thoroughness in examination and continued reexamination were cardinal principles. The prevention clinic was supplemental to the Cancer Diagnostic and Treatment Clinic of the hospital. The clinics now being established in general hospitals, take both men and women. Attendance has exceeded expectation wherever clinics have been opened.

Space does not permit detailed recounting of operational and recording methods of the clinics. Health Maintenance is an important part of this work. Many more cases were referred to private physicians than were sent in by them. The clinics and recording and follow-up are maintained in conjunction with the private physicians. A flat examination charge is reassuring to the prospective patient who may be anxious about unspecified or cumulative charges. Until the clinic registrations are larger and actuarial experience accumulates, a clinic should have a reserve fund for the more expensive examinations. The patients must have emphasized that there is no guarantee of cancer prevention. That inaccessible tumors remain very difficult to diagnose early, that periodic examinations are essential, and that one must return and report an untoward symptom when it occurs, and follow recommended treatment. It is deemed inadvisable to set up a clinic unless it will operate for at least five consecutive years.

For years the insidious and painless onset of cancer has been known, but no one organized and made provision that examinations should be made prior to the time when the patient complained of symptoms.

Eighty-five per cent of skin cancer, 90 per cent of lip cancer, 80 per cent of uterine cancer,

and 75 per cent of breast cancer can be cured when diagnosed early, and promptly and adequately treated. To take these statistical estimates off paper, and make them clinical realities is the purpose of the cancer prevention clinics. A purpose sanctioned by intelligent humanitarianism.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### The Los Angeles County Physicians' Aid Association FOR THE RELIEF AND CARE OF WORTHY, NEEDY PHYSICIANS

*Sponsored by the Los Angeles County Medical Association.*

*Whole-heartedly supported by an increasing number of members of the Profession.*

*Subscriptions are Income Tax exempt.*

• • •

#### WHAT IS THE LOS ANGELES COUNTY PHYSICIANS' AID ASSOCIATION?

The Los Angeles County Physicians' Aid Association is a nonprofit corporation operating under the laws of the State of California.

Its officers and members of its Board of Trustees are members of the Los Angeles County Medical Association. Its books and records are open to the Board of Trustees of the Los Angeles County Medical Association for inspection and suggestions at all times. No activity of any moment is engaged in by the Los Angeles County Physicians' Aid Association without the approval of the Board of Trustees of the Los Angeles County Medical Association.

Members of the Committee on Relief and Fraternal Relations of the Los Angeles County Medical Association take a most active part in the management of the Los Angeles County Physicians' Aid Association.

#### Officers and Directors

Elizabeth Mason Hohl, M.D.	.....President
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Orrie E. Ghrist, M.D.	.....Vice-President
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#### I WILL GIVE

CASH                      CHECK                      PLEDGE  
(Tax Exempt)

To

#### LOS ANGELES COUNTY PHYSICIANS' AID ASSOCIATION

1925 WILSHIRE BOULEVARD  
LOS ANGELES 5, CALIFORNIA

*For the purpose of helping needy doctors or their fam-*

ilies who through no fault of their own find themselves in distress.

This money will be placed in the fund OF PHYSICIANS, FOR PHYSICIANS, BY PHYSICIANS.

Signed.....

\* \* \*

Excerpts from a Letter:

LOS ANGELES COUNTY PHYSICIANS' AID ASSOCIATION  
Los Angeles County Medical Building  
1925 Wilshire Boulevard  
Los Angeles 5, California  
Founded 1937  
October 4, 1944

Dear Doctor Kress:

We are indeed pleased by your interest in us, particularly referring now to the project of the Los Angeles County Physicians' Aid Association.

Our campaign to raise \$500,000.00 is now actively under way. The score at this moment is \$81,346.00. This is being carried on as a "family affair" without recourse to professional agencies.

Sixty-nine of the busiest practitioners in Los Angeles County have accepted assignments as local chairmen in the various areas, hospitals, and buildings in the County. They are functioning with enthusiasm and determination. Admittedly we are all amateurs in this sort of thing and are striving to learn as we go along.

I am enclosing a rather miscellaneous group of some of the material we have used or are using. We have rather definitely concluded that personal individual contact with each prospect is essential to obtaining best results.

We will keep you informed of our progress.

Sincerely yours,

For the House Fund Committee,  
(Signed) LOUIS J. REGAN, M.D.

\* \* \*

Excerpts from Recent Editorial in "The Bulletin" of the Los Angeles County Medical Association:

#### A RARE PRIVILEGE

This issue of the *Bulletin* goes to press just as the campaign of the Los Angeles County Physicians' Aid Association to reach its goal of \$500,000 is swinging into high gear. Enthusiastic volunteers are serving as campaign chairmen, each being assigned to an office building, hospital, or district. Every member of the Association will be given the privilege of making his or her contribution to the fund. Precampaign subscriptions total almost \$70,000. This includes twenty or more gifts of \$1,000.00 and several of \$500.00 or more—striking evidence of the hearty and sincere approval with which the program is regarded.

We all participate in drives to raise money for charity, campaign funds, and other purposes. . . .

No person, however comfortable and apparently secure his circumstances may be, can have any assurance that his health and his financial assets will not be swept away. . . . The present Federal social security program does not include professional workers who are self-employed—we must provide for ourselves. We can do a good job of this without red tape and bureaucracy—two things involved in most governmental projects.

Eligibility for care and assistance from this fund will be determined by rules established by the board of directors of the Physicians' Aid Association with the approval of the board of trustees of the County Medical Association. All members and former members of the Los Angeles County Medical Association will receive preference. Assistance will be given to other deserving physi-

cians and their families whenever facilities and funds permit. No member will be denied care because of failure to contribute to this fund. . . .

Our county medical association has an enviable record of accomplishment. The library, the permanent quarters building, the scientific programs, the innumerable services to members—all of these are fine and laudable. In this present undertaking we are making it very certain that our own medical brethren and their loved ones will never face the spectres of privation and want. The eagerness and enthusiasm with which our members are rushing this program to successful completion is indeed inspiring. Forty-two individuals are receiving aid from the Association at the present time. At the height of the depression more than eighty were being helped. More than half of the beneficiaries have been widows of physicians.

The officers and directors of the Physicians' Aid Association are hopeful that someone will make a gift of a suitable tract of land, perhaps twenty, or thirty acres, as a site for the home. To quote Dr. Louis J. Regan, who is serving as organization chairman, "No one associated with the project is entertaining any fantastic ideas as to the home. Rather, it is contemplated that modest units will be built as they are needed or that war industry units may be purchased and moved onto the property. Further, it is realized that help may be rendered more economically in some instances by aiding in the maintenance of a physician or his family somewhere other than at the home."

The committee in charge of the campaign hopes to reach its objective within two months. To join in this project is a rare privilege and in no sense a burden. Many of our colleagues are giving everything they have on the battlefields. Let us all seize the opportunity to add to the security and safety which they will have upon their return, and to that of their wives and children if they never return.—E.T.R.

(Note. See also CALIFORNIA AND WESTERN MEDICINE, for July, 1944, on page 36.)

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### Southern Pacific Hospital

A vice president of the Southern Pacific who started work for the company as a laborer 25 years ago declared, on February 7, that there is no need for turning control of the railroad hospital over to labor representatives.

D. J. Russell, vice president in charge of the company's hospital department, was testifying before the arbitration board which is conducting a hearing at the Appraisers' building on a dispute between 15 railway labor organizations and the railroad about the Southern Pacific general hospital in San Francisco.

Russell, after telling of his work as laborer, track foreman, and in an ascending succession of other posts for the company, said that as a patient at the hospital when he held lower positions he had always been satisfied. He added that now he never goes to any other hospital as he considers the railroad one outstandingly good.

The railroad vice president said the hospital department is not operated for profit, and that when expenditures exceed receipts the company advances funds to make up the difference.

The witness said that the scale of company cash contributions to the hospital at present is \$70,000 a year, and that it also defrays cost of maintenance of various

emergency hospitals, and furnishes free transportation to hospital department employees and patients.

Burton Mason and Henley Booth, attorneys for the railroad, engaged in several clashes with H. P. Melnikow, representing the labor organizations, when Melnikow cross-examined Russell.

"Did you ever belong to any of the railway labor organizations involved in this dispute?" was one of the questions Melnikow asked.

The witness replied that he had not.

At another point, cross-examining Russell on his stand that no change in the managing methods at the hospital is needed, Melnikow asked:

"In other words, you know what's best for the employees—is that your attitude?"

The labor organizations claim that they put up more than 90 per cent of the hospital fund through deductions from wages, and are asking for majority representation on a board of hospital management.

Chief Justice Leif Erickson of Montana heads the arbitration board.

### City Loses in Hospital Case

#### *Court Rules Patient Not Liable for Expense*

Municipal Judge Daniel R. Shoemaker, of San Francisco, on February 7, handed down an opinion to the effect that persons receiving hospitalization in San Francisco public hospitals are not liable for the cost thereof unless an investigation is made by proper authorities as to their ability to pay.

The decision was rendered in the case of the city against a Mrs. William Perry, who was treated at San Francisco Hospital, and subsequently billed for services. The court rendered a verdict in favor of Mrs. Perry, including her costs in the action.

"No evidence was offered of any action by the board of supervisors, as required by the Welfare and Institutions Code, as to whether any investigation was made, or finding, or determination as to the pecuniary ability of defendant to pay, or her other family responsibilities."

Observers said the decision was important because it may affect various other suits the city has pending for recovery of hospitalization.

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (90)

##### *Alameda County (1)*

Bechtol, Charles O., *Oakland*

##### *Butte-Glenn County (1)*

Calahan, L. J., *Chico*

##### *Kern County (2)*

Bernard, Marion, *Bakersfield*

Cutting, George H., *Delano*

##### *Los Angeles County (70)*

Adashek, Eugene Phillip, *Los Angeles*

Amsel, Maxwell Ritter, *Los Angeles*

Anderson, Harold Edward, *Long Beach*

Barrows, Charles Viole, *Santa Monica*

Bower, Daniel L., *San Marino*

Brodwin, Allen L., *Los Angeles*

Burbach, Theodore H., *Beverly Hills*

Carver, Cyril Ellis, *Pasadena*

Caster, John Leslie, *Los Angeles*

Cook, Jesse D., *Huntington Park*

Crosiar, Donald M., *Hawthorne*

Cruice, Leman D., *Alhambra*

Crumrine, Martin H., *Los Angeles*

Currier, Wilbur Dale, *Pasadena*

de Dworzak, Zdenko V., *Santa Monica*

Denmain, Herman H., *Los Angeles*

Dollinger, Alethea M., *San Gabriel*

Eisenbeiss, John A., *Los Angeles*

Failing, Joseph Henry, *Los Angeles*

Fantl, Kurt, *Duarte*

Field, John Weslie, *Burbank*

Fisher, Louis J., *Glendale*

Flynn, John F., *Santa Monica*

Gilrane, John J., *Fort Lyon, Colorado*

Gottfredson, Elmer J., *Alhambra*

Gray, Arthur S., *Long Beach*

Gregorius, H. Harvey, *North Hollywood*

Hoffman, Peter Louis, *Los Angeles*

Hubbard, Cleon K., *Legion, Texas*

Kellogg, William A., *Long Beach*

Kettenbach, Floralou, *Los Angeles*

Le Tuorneau, Norman H., *Glendale*

Leviton, Max I., *Los Angeles*

Lieberman, Herman S., *Beverly Hills*

Lipkis, Maurice Leonard, *Beverly Hills*

Macklet, Helen, *Los Angeles*

Marcot, Neal A., *Los Angeles*

Mazur, Harold, *Los Angeles*

McClelland, Preston H., *Santa Monica*

McIntosh, Thomas William, *Pasadena*

Moshos, Don Carlos, *Torrance*

Murphy, Clarence F., *Pasadena*

Nardini, Harry M., *Los Angeles*

Nicholson, Roscoe M., *Los Angeles*

Nystrom, S. Robert, *Glendale*

Pies, Morris, *Los Angeles*

Puttler, S. D., *Alhambra*

Quillen, Lawrence J., *Alhambra*

Roberts, Walter L., *Los Angeles*

Rodi, Albert H., *Los Angeles*

Rosen, Samuel, *Los Angeles*

Sapiro, N. A., *Beverly Hills*

Scarborough, Marianne, *Los Angeles*

Schillinger, Robert J., *Los Angeles*

Shepard, Lyle, *Glendale*

Silver, Abraham Joshua, *El Monte*

Smith, Hershel I., *Huntington Park*

Spickerman, Harold DeWitt, *Los Angeles*

Stout, Orin Milton, *Los Angeles*

Test, William B., *West Los Angeles*

Troxler, Eulyss Robert, *Los Angeles*

Tutunjian, Khacher H., *Los Angeles*

Van Buskirk, James Dale, *Los Angeles*

Watson, Blake Halverson, *Los Angeles*

Weil, Hans Joseph, *Altadena*

Whittier, John Coburn, *Glendale*

Wilson, John Walter, *Los Angeles*

Wunderlich, Edwin E., *Los Angeles*

Yengst, Henry L., *North Hollywood*

Zell, Harry J., *San Marino*

##### *Orange County (2)*

Pease, George Norman, *Corona Del Mar*

Saylin, Joseph, *Orange*

##### *San Bernardino County (1)*

Grow, Walter L., *San Bernardino*

##### *San Diego County (5)*

Barton, Robert E., *San Diego*

Ing, Henry, *San Diego*

Turkus, Edward Newton, *Vista*

Walter, F. J., *San Diego*

Werelius, W. R., *National City*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

*San Francisco County (5)*

Bayer, Leona Mayer, *San Francisco*  
 Bernhard, Russell W., *San Francisco*  
 Fishman, Louis Zolo, *San Francisco*  
 Gara, George, *San Francisco*  
 Griswold, Herbert Edward, Jr., *San Francisco*

*Sonoma County (2)*

Robinson, Clinton W., *Santa Rosa*  
 Young, Edith F., *Sonoma*

*Ventura County (1)*

Monahan, John R., *Ornard*

**Transfers (7)**

Curphey, Wilfred C., from Marin County to San Joaquin County.  
 Hanssen, Egil, from San Bernardino County to Los Angeles County.  
 Loewenberg, Richard D., from Lassen-Plumas-Modoc County to Kern County.  
 Lord, Dorothy, from Butte-Glenn County to Los Angeles County.  
 Merret, Russell, from Siskiyou County to San Francisco County.  
 Pennes, Alexander H., from Orange County to Los Angeles County.  
 Rogers, Arthur E. T., from Tulare County to Los Angeles County.

## In Memoriam

**Bahrenburg, George Edward.** Died at Bakersfield, December 20, 1944, age 64. Graduate of the University of Southern California, School of Medicine, Los Angeles, 1903. Licensed in California in 1903. Doctor Bahrenburg was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Schlageter, Herman Joseph.** Died at San Francisco, January 19, 1945, age 73. Graduate of the Cooper Medical College, San Francisco, 1895. Licensed in California in 1895. Doctor Schlageter was a member of the San Francisco Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Smith, Bertnard.** Died at Los Angeles, January 23, 1945, age 66. Graduate of the Rush Medical College, Illinois, 1903. Licensed in California in 1906. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Taubles, Gustave Herman.** Died at Carmel, January 24, 1945, age 65. Graduate of the Cooper Medical College, San Francisco, 1908. Licensed in California in 1908. Doctor Taubles was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Wemple, Emmet Leroy.** Died at Verdugo City, February 10, 1945, age 70. Graduate of the University of California Medical School, Berkeley-San Francisco, 1900. Licensed in California in 1900. Doctor Wemple was a member of the Los Angeles

County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

## CALIFORNIA PHYSICIANS' SERVICE†

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**C.P.S. Beneficiary Members**

	December 1943	December 1944
Commercial Program .....	58,508	107,000
Rural Health Program .....	2,400	2,045
War Housing Program .....	20,675	15,000
<b>Total Membership .....</b>	<b>81,673</b>	<b>124,045</b>

\* \* \*

Some of the investments that the medical profession has made through the medium of reduced fees during the formative periods of C.P.S. may now be returning some dividends.

In the current upheaval of the medical situation in California, there are all kinds of proposals being loosely flung around. There are violent discussions regarding the methods of the rendition of medical care. There are the fee for service, capitation and group methods. Also looming on the horizon, more and more, there is the cost of medical care under any of these systems. The Governor's bill admits that they are not quite sure that the 1½ per cent from the employee plus the 1½ per cent from the employer will be sufficient to cover costs, in that the bill will open the State Treasury to any possible deficit. Most of the other bills have been based on theoretical assumptions that have probably originated from study groups of the C.I.O. research committees who, in part, may have drawn upon the advice and counsel of foundations, academic resources and Social Security or Public Health Service statistics. Or they may have drawn upon some isolated experiment, or a going plan or plans covering limited numbers of people in restricted geographical areas and under special conditions.

All of these conceptions of the cost of medical care have not been put to an actual test from a practical point of view. It is well-known to California Physicians' Service that theoretical conceptions of the cost, based on the best information obtainable, have resulted on many occasions in unsatisfactory experience when put to an actual test. It is a well-known fact among people interested in medical administration that it takes more than analytical research juggling available figures to predict costs under any program. There is always present the unknown quantity of the human reaction to any plan. The effect of this can only be obtained by actual experience and exposure to the people who are to receive the care as well as to the physicians who will render that care.

†Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M.D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

C.P.S. has been called upon in the past to reveal its experience. It has done so before the Pepper Committee in Washington, and the information given there has made a genuine impression, and it is reasonable to believe that it has caused thinking relative to medical care plans to become a little bit more practical. This could be a very healthy sign in a subject that has been almost universally approached from purely an emotional point of view. In our own State, under present legislative proposals, the six years of experience of California Physicians' Service, with all of the factors of medical care being exposed on the day-to-day basis during this time, and the handling of several hundred thousand people, must certainly appeal to those legislators and other interested people who would approach this subject with an open mind and with mature judgment as being of great significance. It cannot be by-passed.

Along these lines, C.P.S. was able to turn over to the California Medical Association a large wealth of such information, and it is currently being used in the discussions of the various health plans. The latest reports from the Assembly hearings indicate that it is carrying considerable weight and stimulating these people to perhaps another line of thinking. C.P.S. has sufficient information accumulated over a long enough period of time and in sufficient volume, of different experiments in medical care with the Commercial, War Housing and Rural Health Programs, so that it is able to predict the costs under various methods of rendition of medical care, whether it be fee for service, capitation or group service.

All of these have led to the inescapable conclusion that modern medicine has far out-jumped the guesses of those who were talking in terms of 3 per cent payroll deductions, some 10 to 15 years ago. The cost of American Medicine, as it has developed scientifically through slow evolution, has been clearly demonstrated. This information alone, which no one can controvert with any similar data other than pure theoretical assumptions, may be one of the great contributions C.P.S. will make to the practice of medicine in the State of California.

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Accident Reduction

#### *National Safety Council's Contribution to War Effort By Saving of Millions of Man-Hours*

The National Safety Council has made a substantial contribution to the nation's war program. Its three years of constant campaigning to reduce accidents in industry and in the home has resulted in the saving of millions of man-hours, and has furthered our production to that extent.

It is good news that the campaign, supported by the contributions of business and industry, is to be continued, and that a fund of \$1,000,000 will be sought with which to carry on this important educational work during 1945.

There has been steady improvement in the national accident rate since the council's program was put into effect. Last year there were 3,500 fewer accidental deaths than in 1943, and there was, in addition, a decrease in the number of non-fatal accidents.

This saving in manpower prevented a possible breakdown in some channels of essential industry; it reduced potential fire losses, and it preserved unmeasurable quantities of equipment and supplies from damage or destruction. These are indeed huge results.

"Until about three years ago," says a bulletin from the Council, "safety work in this country was confined largely to the fields of industry and traffic, with the

result that no strongly organized effort was being made to prevent about half of our accident losses. When it is considered that these losses amounted to nearly 100,000 people killed, 9,000,000 injured, 350,000 permanently disabled and a \$5,000,000,000 economic loss every year, it seems obvious that some serious effort to bring the situation under control was inevitable."

The National Safety Council's public service program represents the first organized effort to be directed against all types of accidents, both on-the-job and off-the-job. It is conducted on a coast-to-coast basis, through the national and four regional offices and by local chapters, one of which is in San Francisco.

While its organization resulted from business and industry accepting for themselves a special and added responsibility to assist the nation in time of war, it is to be hoped its efforts will not terminate with the coming of peace. There will always be a need for this important work.

### Disease Observes No Geographical Boundary Lines

Health is something that all nations desire, and no nation by the process of gaining it takes it away from another. There is not a limited supply of health for which nations must compete. Rather, every nation by promoting its own health adds to the better health of other nations, just as by assisting in the public health efforts of other nations we protect ourselves.

Here is a field of common interest to the race of man everywhere on the planet. Interpreted in broad, positive terms to embrace physical, mental and moral fitness, it can be a nucleus of international activity which will encourage emulation in other and more difficult fields.

What the League of Nations did in Geneva through its International Health Organization can be the starting point and basis of a far broader and better supported work.

A new worldwide epidemiological intelligence system, the standardization of biological products, the organized exchange of public health personnel to broaden the technical outlook and stimulate the imagination of health officers, the supplementation of public health activity in countries where it is inadequate, the development of minimum standards of acceptable public health work that can be applied on a worldwide basis, the creation of commissions of experts and international conferences on such subjects as malaria, yellow fever, rabies, nutrition, housing, rural hygiene, physical education, social security—these are only samplings of the activities which could profitably be pursued, perhaps on a regional basis, by a new International Health Organization.

Work in public health which disregards flags and boundary lines has become in our generation essential to the safety of the human race everywhere. Public health can no longer be thought of exclusively in national terms. In a world as closely knit as ours, what menaces one country menaces another, whether it be disease or disaster.

Take, for example, the yellow fever situation. There has never been any yellow fever in India or in the Orient, and consequently no immunity against the disease has been built up, as in Africa and South America. India is therefore a tinderbox, and a single infected mosquito could break down all the barriers of quarantine, vaccination and medical vigilance.

No nation by its own acts alone can protect itself from such an overshadowing menace. It requires united, cooperative action in which boundary lines are overlooked and conceptions of sovereignty are relegated to the limbo of forgotten things.

The gambiae mosquito furnishes another illustration. For centuries it has been the scourge of Central Africa.

Until 1930 this mosquito was unknown on this side of the Atlantic. But a new line of planes began to bring passengers to Brazil and the gambiae came along, too; the terror of that visitation is deeply engraved on the memory of northeast Brazil.

This poses a problem which cannot be evaded. The safety of the Western Hemisphere, now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit gun campaign. If the Americas are to be protected adequately, the breeding places of gambiae, wherever they may be found, must be

eradicated or controlled. The campaign must be carried to the sources of infestation. It must be offensive.

This newly made world which the airplane has tied together has lost its frontiers. Whether we like it or not, the propinquity of modern life now confronts us with inescapable demands for new techniques. We are living in the Twentieth Century and we cannot retrace our steps back into the Nineteenth. Our only hope of survival lies in collaboration across boundary lines.—From an address by Raymond B. Fosdick, president of the Rockefeller Foundation, reprinted in the American Journal of Public Health and in the Fresno Bee, January 21.

(COPY)

### Los Angeles City Health Department

#### COMMUNICABLE DISEASES TO BE EXCLUDED FROM SCHOOL

Disease	Incubation Period	Exclusion Period of Patient	Exclusion Period of Contacts
Chickenpox	14 to 21 days	For 7 days after appearance of the rash and all scabs off	None if patient is properly isolated
Conjunctivitis (pink eye)	1 to 5 days	Recovery	None
*Diphtheria	2 to 7 days	5 days followed by 2 negative nose and throat cultures taken 48 hours apart, from City Health Laboratory	7 days and 1 negative culture from the nose and throat, from City Health Laboratory
Diphtheria Carrier	.....	Until 2 negative cultures of the nose and throat, 48 hours apart	1 negative nose and throat culture
Dysentery (Bacillary)	2 to 7 days	Same as typhoid. Release specimens 3 days apart	None
Encephalitis (Infectious)	4 to 14 days	7 days from onset	None if patient is properly isolated
German Measles	14 to 21 days	Recovery	None
*Gonococcus Infection	3 days or more	Until non-infectious	Health officer decides
Influenza	Up to 2 days	Recovery	None
Impetigo	.....	Short	None
Jaundice Infectious	One week	Recovery	None
Measles	9 to 12 days	At least 7 days after appearance of the rash	None if school medically supervised inspection available
*Meningitis (Meningococcus)	2 to 10 days	14 days from onset and clinically well	14 days from last contact
Mumps	8 to 30 days	Swelling completely subsided	None
Pneumonia (Infectious)	.....	Until 5 consecutive days of normal temperature	None
*Plague	5 to 7 days	Health officer decides	Health officer decides
Psittacosis	6 to 15 days	Recovery	None
*Polio-myelitis	3 to 14 days	14 days from onset and clinically well	14 days from last exposure
Pediculosis	.....	Unknown	None
Ringworm	Unknown	Recovery	None
Scabies	Unknown	Recovery	None
*Scarlet Fever	2 to 7 days	21 days from onset and clinically well	7 days from last exposure
Septic Sore Throat	1 to 3 days	Recovery	None
*Smallpox	8 to 21 days	Recovery and crusts or scabs disappear	Until immunity established
Syphilis	.....	Until non-infectious	Health officer decides
Trachoma	Unknown	Health officer decides	None
*Tuberculosis	Slow	Health officer decides	None
Typhoid and Paratyphoid	7 to 23 days	5 days normal temperature and 2 negative stool and urines, 5 days apart	None. Should be immunized.
Typhus Fever	5 to 20 days	Recovery	None
Whooping Cough	7 to 10 days	21 days from appearance of paroxysmal cough or until complete recovery	None if school medically supervised inspection available
*Yellow Fever	2 to 6 days	4 days after onset of fever	7 days from last exposure

**Dog Bites:** Reportable; immediate cauterization, with fuming nitric acid, and neutralization with sodium bicarbonate solution, important.

**Food Poisoning:** Report at once by telephone—Michigan 5211, Station 424.

**NOTE:** All infectious diseases (food poisoning included) must be reported promptly. Your cooperation will be appreciated.

Any child absent from school on account of illness for five days or more (Saturdays and Sundays included) MUST HAVE A RE-ADMITTANCE CARD before being permitted to reenter school. In the case of all or any diseases that have been quarantined, and in the case of all diseases indicated by an asterisk, re-admittance card must be issued by a Health Department official only. In all other cases, any registered physician, surgeon, or school nurse may issue re-admittance cards, subject to the discretion of the Health Officer. A pupil who has been absent from school for a period of more than five days (Saturdays, Sundays and Holidays included), on account of a minor illness, KNOWN TO BE NON-CONTAGIOUS, may be readmitted by the principal, except during an epidemic period.

GEORGE M. UHL, M. D.,  
Health Officer

## MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

### NEWS

#### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

See editorial comment, in this issue.

**American Medical Association.** The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

#### The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

(Note: For interpretative comments, see J.A.M.A., June 24, 1944, pp. 574-576.)

#### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In March, KFAC will present these broadcasts on the following Saturdays: March 3, 10, 17, 24, and 31.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p. m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

#### Pharmacological Items of Potential Interest to Clinicians\*

1. **Symposia:** Covering all phases of nutrition, and led by Sir Edward Mellanby (*Brit. Med. Bull.*, 2:202-254, 1944). Very important one sponsored by New York Academy of Science on energy relationships in enzyme reactions, by J. S. Fruton, E. G. Ball, M. Bergman, H. M. Kalckar, O. Meyerhof, and C. V. Smythe (*Ann. N. Y. Acad. Sci.*, 45:357-436, 1944). N. Y. Academy holding important one on hypertension, Feb. 9 and 10, at American Museum of Natural History, N. Y. F. A. Lawes and B. Williams hold forth on fatigue (*Med. J. Austral.*, 2:501-507, Nov. 11, 1944).

2. **Gas:** Look carefully into E. N. Harvey & Co.'s important studies on bubble formation in animals (*J. Cell. Comp. Physiol.*, 24:1, 23, 117, 133, 257, 273, 1944). J. W. Bean fully reviews effects of oxygen at increased pressures (*Physiol. Rev.*, 25:1, 1945).

3. **Cancer:** Add symposium by staff of Barnard Free Skin and Cancer Hospital (*Surg. Clin. North America*, Saunders, Philadelphia, 1944, pp. 981-1268). R. Leuchtenberger & Company report "folic acid" (L. casei factor) IV injections cause regression and prevention of spontaneous mouse breast cancers (*Science*, 101:46, Jan. 12, 1945). V. R. Potter & Co. show that energy metabolism enzymes increase 3 fold after birth (*Cancer Res.*, 5:21, 1945). Note M. J. Shear & Co.'s series of articles on chemical treatment of tumors with hemorrhage producing polysaccharide from *Serratia Marcescens* (B. prodigiosus). These are summarized in clinical report (*J. Nat. Cancer Inst.*, 5:195, 1944), and refer to W. B. Coley's work (*Glasgow M. J.*, 126:49, 128, 1936) and G. Schwartzman's *Phenomenon of Local Tissue Reactivity* (Hoebel, N. Y., 1937; *Cancer Res.*, 4:191, 1944). F. Duran-Reynals shows importance of host resistance factors in enoplastic reactions to rabbit fibroma virus (*Cancer Res.*, 5:25, 1945). J. P. Greenstein and F. M. Leuthardt describe degradation of cystine peptides by exocystine desulfurase (*J. Nat. Cancer Inst.*, 5:209, 1944; *Science*, 101:19, Jan. 5, 1945). F. E. Chidester writes on *Nutrition and Cancer* (Lancaster Press, Pa., 1944).

4. **Therapy:** L. Loewe recommends combined use of penicillin and heparin in subacute bacterial endocarditis (*Canad. Med. Asso. J.*, 52:1, 1945). A. F. Coburn discusses control of streptococcus hemolyticus (*Mil. Surg.*, 96:17, 1945). L. W. Smith and A. E. Livingston recommend 1 per cent chlorophyll ointment containing 250 units penicillin per gram for promotion of wound healing (*Am. J. Surg.*, 57:30, 1945). D. Greiff & Co. find para-amino benzoic acid orally effective vs. murine typhus in mice, and PBA and penicillin rickett-siostatic, while NaFl is the reverse! (*J. Exp. Med.*, 80:561, 1944). F. M. Allen summarizes treatment of surgical shock and embolism by preventing fluid loss, replacing fluid lost, and local and general refrigeration (*J. Internat. Coll. Surg.*, 7:423, 1944). Note H. McIlwain on theoretical aspects of bacterial chemotherapy (*Biol. Rev. Cambridge Philosoph. Soc.*, 19:135, 1944).

5. **Furthermore:** J. W. Bartholomew and W. W. Umbreit report that ribonucleic acid with magnesium and cell protein is responsible for gram positive staining, and that sulphydryl groups are involved (*J. Bact.*, 48:567, 1944).

\* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

1944). C. Pinto recommends saponin for efficient and economical killing of snail carriers and cercaria of *Schistosoma* in streams (*Mem. Inst. Oswaldo Cruz*, 40:210, 1944). B. D. Davis discusses variety of biologic false positive serologic tests for syphilis (*Med.*, 23:359, 1944). R. M. McKenna notes psychosomatic factors in skin disease (*Lancet*, 2:679, Nov. 25, 1944). In swell discussion of structure and permeability of blood capillaries, J. F. Danielli and A. Steck conclude most substances reach tissue cells after filtration through pores in intracellular cement, and that edema follows Starling's hypothesis of protein gradient in pericapillary fluid and Poiseuille's equation that rate of flow is proportional to 4th power of capillary radius (*Biol. Rev. Cambridge Philosoph. Soc.*, 19:81, 1944). Note our E. H. Frieden's report on diffusion constant of penicillin suggesting molecular weight of 490 (*Science*, 101:21, Jan. 5, 1945). Also F. T. Maher's *Reticulo-Endothelial System in Sulfonamide Activity* (Univ. Illinois Press, Urbana, 1944, \$3.50). And S. Drake's discovery of A. B. Johnson and his works on language (*Rev. Gen. Semantics*, 1:239, 1944). While R. A. Woodbury and B. E. Abreu say yarns and sighs increase venous return, getting blood back to tired heart, ho-hum (*Am. J. Physiol.*, 142:721, 1944).

**Erroneous Insertion of Advertisement in Text Department.**—Owing to an error in the bindery division of the Wolfer Printing Company, printers of CALIFORNIA AND WESTERN MEDICINE, a colored advertisement was placed between text pages 36 and 37 of the January issue. The advertising announcement was marked for placement in the back advertising section, between pages 36 and 37 of that department. Printers have expressed their regret concerning the error.

**Forty-two Conscientious Objectors Risk Pneumonia.**—Experiments with forty-two conscientious objectors, some of whom were inoculated with throat washings from soldiers having atypical pneumonia, have demonstrated that a virus can cause this kind of pneumonia, an Army medical commission reported on January 18.

All the conscientious objectors volunteered for the experiments. They were segregated in individual rooms in a hotel under rigid quarantine for eight weeks.

The inoculations consisted of throat washings and sputum from six patients having atypical pneumonia, which is not typical pneumonia or not like pneumonia caused by bacteria.

Recent studies have shown, the article said, that bacteria, fungi and virus, particularly those of the psittacosis or parrot fever group, may produce a group of symptoms of a disease sometimes called "virus" pneumonia.

Some of the throat washings were filtered through a glass which eliminates all bacteria, but three of the twelve receiving this bacteria free filtrates became sick with primary atypical pneumonia. Twelve men were inoculated with unfiltered material and the same number became ill.

"The results of this experiment thus demonstrate that bacteria free filtrates, presumably containing a virus, can induce primary atypical pneumonia in man," the physicians of the Army Medical Department at Fort Bragg, N. C., concluded.

**Training for Hospital Librarians.**—The School of Library Service at Columbia University will offer in the summer session of 1945 a program pertaining to work in hospital libraries, running from July 2 to August 10. This

is in response to a growing demand, and to a prospective expansion of such work in government hospitals.

Enquiries and requests for application forms may be addressed to the School of Library Service, Columbia University, New York 27, New York.

**Stanford University School of Medicine: Department of Pharmacology.**—Dr. Wei Chang Chu, instructor in pharmacology, Kweiyang Medical College, arrived in San Francisco, January 24th, on leave for two years from the Chungking Government, for work in the department of pharmacology, Stanford University School of Medicine. Dr. Chu is a graduate of the Hunan-Yale Medical College, 1937.

**Mayo Memorial Fund.**—Plans for erecting on the University of Minnesota Medical Campus a center for medical research, teaching and administration as a Memorial to Doctors William J. and Charles H. Mayo have been announced by the Committee of Founders of the Mayo Memorial appointed by Governor Edward J. Thye and headed by Dr. Donald J. Cowling, President of Carleton College.

The proposed 12-story Mayo Memorial building to be erected in the center of the University Hospitals quadrangle will be constructed at a cost of \$2,000,000. The committee visualizes the Memorial as contributing much to the general public, to industry, to practicing physicians, to nurses and to medical students.

It will contain a Memorial auditorium, research laboratories, conference rooms for clinical departments, and the department of Pathology, the operating rooms and major laboratories of the University Hospitals, the administrative offices of the Medical School, the School of Nursing, the University Hospitals and the Department of Post Graduate Medical Education. By assembling these and other facilities under one roof the Mayo Memorial will create in fact a great medical center where research, training and treatment go forward hand in hand every minute of every day—thus carrying on through many generations the work so nobly advanced by the Mayos.

The Committee of Founders believes that all friends of the Doctors Mayo will wish to help make the Memorial a reality. There will doubtless be many others who may not have known the Mayos personally but who know of their remarkable work and will desire to participate in this tribute.

Further details on the proposed Memorial and a descriptive booklet may be obtained by writing to the Mayo Memorial Fund, 1126 N. W. Bank Building, Minneapolis 2, Minnesota.

**A Tribute to the Country Doctor.**—Last spring a woman of culture left her home in one of America's principal cities to spend six months in Arkansas. Soon after her arrival she came down with a common ailment and needed a surgeon. Her new neighbors almost failed to convince her that the village doctor was safe to consult. She asked: "If he's so wonderful, what's he doing here? A really good doctor can make a lot of money in a city."

She was right on one point. This doctor *could* make a lot of money in a city. He has not fared poorly where he is, but he never will be rich. He is not so much interested in money, however, as in a certain kind of success that's not measurable in dollars. He has a priceless estate of human lives. He can't leave his house without meeting people who owe their very existence to his skill.

A Rich Estate

This country doctor has the unfeigned love of his

neighbors. His work and ethics have their unqualified approval, but that's only part of the story. He likes *them* too. Nobody suffers for medical attention where he lives. "He gets paid for it," do you say? Yes, he collects from about half his patients. But the humblest share-cropper can have the best doctor he ever heard of, and never see a bill.

Writing this, I have a particular physician in mind, but I'm satisfied you are thinking about another doctor as you read it. There is one in just about every country town; two or three in big places. America still has plenty of neighborhoods where men grow up and live to a ripe old age at one address. These are the spots where a doctor is a real person, not just a service.

### The Case History

Knowing the people in his neighborhood is worth a great deal to a physician's success. Even a specialist, who treats strangers almost exclusively, will agree that a patient's history is more helpful to the doctor than an examination. That's why I don't want to swap doctors with you, and I hope you feel the same way. Together, we can save this country from the political curse of socialized medicine.

A firm protest from the forks of the creek, mountain coves and farming towns can keep the Wagner National Health Bill, now decomposing in a pigeon-hole of a Senate subcommittee, from ever coming to life. It was introduced with small hope of passage, its chief purpose perhaps was to raise the issue and start people talking about medical service as something to be standardized and rationed like gasoline.

My doctor is a busy man. He works more nearly 16 hours a day than eight. A standardized working week of, say, 40 hours for him would make two new doctors in our neighborhood necessary. Of course both new men would have to study the community's health record, have to be as well schooled as the older doctor and have to receive suitable salaries.

It would be a bad deal, three ways:

1. Some of my doctor's patients would have to accept treatment from a man with all to learn about *them*.
2. Since three men cost more to maintain than one, all of us would spend more money for medical aid.
3. My good doctor wouldn't be busy. This is the worst feature. The work he loves (his estate of lives) would be taken away from him. I figure this agile mind would turn to something else, and that he'd quit being a doctor at all.—George S. Benson, President of Harding College, Searcy, Arkansas, in the Commentator column, "Looking Ahead" in the *Sacramento Commercial News*, December 15, 1944.

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

### Kaiser's Profits

*Congressman Says \$100,000 Investment in War Industries Yielded Millions*

Washington, Feb. 23.—(AP.)—Henry J. Kaiser [founder of Permanente Hospitals] founded his war industries on a private investment of \$100,000, and two of the firms have shown a profit of \$27,274,487, according to a statement entered into the *Congressional Record* by Representative Woodruff (R., Mich.).

"Mr. Kaiser, without a doubt, has done a magnificent job in contributing to the success of our armed forces," Woodruff said in his statement.

"He has displayed a capacity for organization and production that amazes everyone familiar with his record. However, his efforts have not gone entirely unrewarded."

Quoting information he said he obtained from the Comptroller General's office, Woodruff's statement said the profit figure was after contract renegotiation but before taxes and added:

"It seems, Mr. Speaker, that when the reports on the other companies are finally in it will be found that the

original \$100,000 investment was a decidedly profitable one."

Woodruff said the Government had spent \$216,647,743 in providing facilities for seven Kaiser companies, and "it will be noted that the original investment of the Kaiser group was \$100,000."

Woodruff told a reporter he referred only to the Kaiser "war babies"—companies set up beginning in 1941 to handle war contracts—when he spoke of the original private investment.

Some Kaiser companies were operating long before the war began, but Woodruff said he is not concerned with their cost, investment or profits.

With his statement, Woodruff put in the record a detailed report from the Comptroller General's office on the financial structure of these associated Kaiser companies—California Shipbuilding Corporation, Kaiser Cargo, Inc., Marinship Corporation, Oregon Shipbuilding, Permanente Metals Corporation, Richmond Shipbuilding Corporation, and the Walsh-Kaiser Co., Incorporated.

The report showed renegotiated profits before taxes through 1943 of \$16,551,324 for the California Shipbuilding Corporation, and of \$10,723,163 for the Oregon Shipbuilding Corporation. Profits for the other five companies were not listed.—*San Francisco Chronicle*, February 24.

### Warren Denies Housman Plea

*Governor Refuses to Pardon Former S. F. Doctor*

Attempts of Nathan S. Housman, former San Francisco physician, who served a prison term for perjury, to obtain a pardon and restoration of his medical license suffered a sharp setback on February 16 at the hands of Governor Warren.

Taking direct issue with Superior Judge Lille T. Jacks of San Francisco, who recommended "rehabilitation" of Housman, the Governor refused to pardon the former physician.

The Governor pointed out that in his recommendation Judge Jacks had gone counter to the law, which specifically provides that a petition for rehabilitation cannot be filed until the petitioner has lived continuously in the county of filing for at least three years before filing.

Housman, the Governor recalled, was paroled on December 18, 1942, and Judge Jacks granted him a certificate of rehabilitation on October 16, 1944—a period considerably less than the minimum required by the law. Said the Governor:

"In my opinion, a sufficient time has not elapsed to demonstrate Doctor Housman's rehabilitation, nor has he satisfied the statutory requirement of three years' residence. For these reasons, I have denied Doctor Housman's application for pardon."

The denial is expected to exert decisive influence over the decision of the State board of medical examiners, which will hear Housman's petition for restoration of license at Los Angeles on February 27. Doctor Housman's license was automatically revoked when he was convicted of a felony—two counts each of perjury, offering false evidence, and preparing false evidence.

These offenses occurred during trial of a misdemeanor charge against Doctor Housman: Omitting to keep proper records of narcotics prescriptions.—*San Francisco Examiner*, February 17.

### Work Insurance

*Economist Asks Living Wage, Medical Care, Job Guarantee*

Washington, Feb. 18.—A post-war Government guarantee of a job for every person able and willing to work, as well as a guaranteed minimum living standard, was proposed today by a Federal economist.

E. A. Goldenweiser, chief economic adviser to the Federal Reserve Board and with the board for 26 years, advanced both ideas in a suggested program aimed at 58,000,000 postwar jobs.

"If a person has done all he can to find a job and still can't find one, the Government ought to offer him a job," the economist said, in the current issue of the *Federal Reserve Bulletin*.

"We have a kind of minimum now in that we don't intend to have anyone starve or freeze or go without shelter, but it differs too widely.

"It depends too much on the disorganized action of individuals and groups.

There should be established a standard of living below which no person in this country needs to fall under any circumstances; a minimum of food, a minimum of clothing, and minimum of shelter, education and medical care and even of money."—*San Francisco Chronicle*, February 19.

### College Heads Ask Delay in Post-War Training

Twelve leading educators, including the presidents of Stanford and the University of California, said recently in a letter to President Roosevelt that it would be unwise and dangerous to commit the nation to compulsory post-war military training "under the tension of war psychology," the United Press reported from Washington.

They urged him to delay at least until Germany is defeated his proposed message to Congress requesting a year's training for all youths so the people can reach "a wise decision . . . after a cool debate."

Suggesting that prohibition had demonstrated the danger of trying to decide long-range policies in wartime, the educators said proponents of military training show a distrust of the people when they argue it wouldn't be adopted unless Congress acts under the stress of war.

"It is to imply that the people cannot arrive at a wise decision on a great issue through the democratic processes," the letter said. "With the great body of Americans, we all will support a year of compulsory training if, after adequate deliberation, the nation is convinced that its safety requires it."

The letter was signed by the presidents of 12 universities—James B. Conant, Harvard; Oliver C. Carmichael, Vanderbilt; Edmund E. Day, Cornell; Harold W. Dodds, Princeton; Rufus C. Harris, Tulane; Robert M. Hutchins, University of Chicago; Frederick A. Middlebush, Missouri; Deane W. Malott, Kansas; Robert G. Sproul, California; Donald B. Tresidder, Stanford; Herman B. Wells, Indiana, and Henry M. Wriston, Brown.

Denouncing the post-war training proposal as nothing more than "peacetime conscription," they set forth these arguments in opposing it at the present time:

1. It is not related to the successful prosecution of the war.
2. Its adoption would be a revolutionary change in fundamental American policies, a move that would be "extremely unwise and even dangerous" until the post-war international situation is clarified.
3. Peacetime training is only one phase of a rounded defense program and "to adopt it under the stress of war and have it prove unwise might jeopardize an intelligent long-run defense program."
4. It is impossible to "determine intelligently" the extent of defense measures that will be needed after the war since "no one can now foresee the international situation when the war is over."
5. "The people are fighting the war with high hope it will eventuate in an enduring peace. If Congress should now prescribe a year of compulsory military training, the action together with the necessary accompanying measures for mobilizing industry and science would be interpreted as meaning that we must continue to live for an indefinite period in an armed camp."—San Francisco News, January 31.

### Harry Hopkins Urges Compulsory Military Training

Washington, Feb. 1.—(UP).—Harry L. Hopkins, President Roosevelt's right hand man and often the unofficial but on-stage voice of Administration policy, today called for compulsory military training of American youth as a standing menace to future German and Japanese aggression.

Writing in the current issue of *American Magazine*, he said:

"I have no doubt that powerful forces in Germany and Japan are preparing even now for their next attempt to conquer us. We will try to keep them impotent, but only a perpetual army of occupation would be able to prevent them from rearming eventually."

Compulsory military training should include every 18-year-old boy, omitting only those who are incapable of mental or physical rehabilitation he said. Married youths, 4-Fs and "necessary" workers must be included because the American people will not approve a program which permits some youths to "appear to be ahead of their friends who return from training camps."

He rejected the idea that a year of training would turn the Nation into a military machine made up of regimented men and create a Hitler-like youth movement. On the contrary, he said, boys would be taught trades, illiterates would learn to read and write and "thousands who are ailing, thousands who can be rehabilitated by operations, will be made well."

Congress should pass a law providing for compulsory training, he said, but only after "thorough consideration of every objection that can be advanced."

"This is no time to rush through a law that may inspire increasing opposition," he wrote. "If we inaugurate a kind of military training that fathers and mothers de-

cide is doing their boys no good, the people will abolish it after a few years—to the delight of our enemies."—San Francisco *Chronicle*, February 2.

### Draft All Nurses, Parran Urges

Washington, Feb. 6.—(INS).—Surgeon General Thomas Parran today recommended to Congress that all nurses be placed under Selective Service and required to perform essential civilian as well as military tasks.

The head of the U. S. Public Health Service, speaking in favor of nurses' draft legislation, told the House Military Affairs Committee:

"We should have a real Selective Service under which each nurse would be required to contribute in proportion to her skill on the military or civilian front."—San Francisco *Call-Bulletin*, February 6.

### Nurse Draft Approved by House Representatives

Washington, Feb. 27.—(IN).—The House Rules Committee today approved the Nurses' Draft Bill, thus clearing away the last obstacle to a vote in Congress, probably later this week, on precedent breaking legislation to induct women into the armed services.

Favorable action was spurred when Representative May, Democrat of Kentucky, chairman of the House Military Committee, disclosed that approximately 515,000 servicemen are now hospitalized; 285,000 in hospitals overseas and 230,000 in this country.

"Some 1,600 men are pouring into field hospitals from the front every twenty-four hours," May told the committee, "or about 11,000 to 15,000 each week, and the number is increasing. In addition, there are another 6,000 men a day who require treatment but no nursing care."

"The need is imminent and imperative." . . .—San Francisco *Examiner*, February 27.

### 8,000 WACs Needed for 63 Hospitals

A new and vigorous drive to recruit some 8,000 WACs for service in the 63 Army general hospitals in the country was inaugurated on February 10th.

Women qualified for training as medical and surgical technicians, clerical and other skilled workers are urgently needed to fill these hospital units to aid in rehabilitation of returned soldiers.

Under the plan, outlined last week by General George C. Marshall, a company of 100 women is to be assigned to each of the 1,000-bed hospitals and an additional company of the same size for each additional 1,000 beds in the larger institutions.

Qualified women enlisted as medical and surgical technicians will be assigned to a hospital unit as students after six weeks of basic military training and six weeks at an enlisted technicians' school. They will receive one month of applicatory training after assignment to the hospital. Upon completion of this training they will qualify as technicians with appropriate Army ratings and will continue on duty at the place of their final training.

Letterman General in San Francisco and Dibble General hospitals are preparing to receive the first companies of local WAC medical technicians. Other hospitals in the area eligible for WAC companies are Hammond General in Modesto and DeWitt General at Auburn.—San Francisco *Chronicle*, February 11.

### New Discharge Plan Bared

#### Victory in Europe to Free 200,000 Month

Washington, Feb. 27.—(AP).—War Department plans to release from 200,000 to 250,000 men a month after the war needs in Europe were disclosed on February 26th.

Brig. Gen. Frank T. Hines, head of the Veterans' Administration, made the disclosure while testifying before the House Appropriations Committee on a deficiency bill sent to the floor today.

The present rate of discharges, Hines asserted, is running around 90,000 monthly. Approximately 700,000 of the 1,600,000 released up to last November 30, he added, were discharged under certificates of disability.—San Francisco *Examiner*, February 27.

### Veterans Need Expanded Health Program, Senator Pepper Says

Washington, Feb. 25.—(AP).—A Senate subcommittee estimated today that between 1,500,000 and 2,500,000 Americans will incur disabilities in the war, and urged that existing health facilities and programs be greatly expanded.

"The men and women in the services have been accus-

tomed to the best in medical and hospital care," said Senator Pepper (D. Fla.), chairman of a subcommittee on wartime health and education which made the report.

"They will not be satisfied with anything less than the best when they return to civilian life."

The subcommittee recommended that the veterans' administration be given responsibility for the medical care of veterans with service connected disabilities, with chief responsibility for the medical care of an estimated 13,000,000 veterans without such disabilities resting on their own communities.

The report suggested that present laws be revised to make it possible for veterans with service connected disabilities to obtain hospitalization and out-patient treatment not only for their service-connected ailments, but for any other disability as well.

Because the committee considers community hospital facilities generally inadequate, it recommended that the Government continue to offer hospital care for any veteran who needs it, when facilities are available and he is unable to pay for private hospitalization.

The Senators estimated that veterans of the current and previous wars, together with their families, eventually may comprise about one-half of the Nation's population. —San Francisco Chronicle, February 26.

#### X-Ray Center Opens in San Francisco

An x-ray chest survey center, where San Franciscans may obtain a free chest x-ray, has been opened by the San Francisco Tuberculosis Association in cooperation with the department of public health, it was recently disclosed.

The center, located in room 200 of the Public Health Building, 101 Grove Street, is open every morning except Saturday and Sunday from 8 a.m. until 12:30 p.m., Saturday morning from 9 to noon and Monday, Tuesday, and Friday afternoons from 1:30 to 4:30.

Equipment, purchased by the Association with funds raised from sale of Christmas seals, is of the type used extensively by the armed services. —San Francisco Examiner.

#### V.D. Control Program in Industry

Well-established, the principles which the U. S. Public Health Service urges, may be briefed:

I. *Education*.—Planned campaign so that both employer and employee will understand the diseases. . . .

##### II. *Employment*.—

(a) If a person has infectious VD, he or she should be: (1) Referred to a private physician or clinic for confirmation of diagnosis and treatment; (2) returned to work or employed when rendered noninfectious; (3) persuaded to continue treatment until doctor pronounces the therapy adequate.

(b) If a person has noninfectious VD, he or she could be: (1) Referred to a private physician or clinic for confirmation of diagnosis and treatment; (2) retained on the job.

(c) If late manifestations of the disease are found (such as cardiovascular syphilis, gonorrheal arthritis, etc.): Doctor should recommend person for a job he is physically and mentally capable of doing with safety to himself and fellow workers.

(d) Follow-up: (1) Arrangements made to care for case by treatment by private physician, plant doctor, or clinic; (2) Attending doctor keeps plant doctor posted on regularity of treatment and progress of patient; (3) Refusal to take continued treatment leads to doctor notifying management; (4) Names of infectious cases sent to health dept. for epidemiological investigation.

##### III. *VD Medical Examination*.—

(a) Recommended for all employees.

(b) Should include serodiagnostic tests for syphilis.

(c) Gonorrhea smears or cultures, when indicated.

(d) Interval: (1) Preemployment; (2) when doing periodic examinations; (3) return-from-illness examinations; (4) no more than 3 years between examinations.

(e) Results of examinations are confidential information of the attending physician and plant medical service. Does anybody agree with these, act upon them?

If interested in further details on any aspects of VD control in industry, write Otis L. Anderson, Senior Surgeon, Assistant Chief, Venereal Disease Division, U. S. Public Health Service, Bethesda, Maryland. —V. D. War Letter.

#### Use of Mineral Oil in Salads Decried

The increased use of mineral oil in salad dressings,

salted nuts, potato chips and doughnuts may have serious nutritional consequences, the state agricultural college said today.

According to Nebraska officials, mineral oil robs the body of at least two of the fat-soluble vitamins necessary to health, and also of two important minerals, calcium and phosphorus.

Mineral oil recently has come into wider use in food preparations, it was said, because it is not rationed, is plentiful, reasonably cheap and does not become rancid.

Studies at Massachusetts, Pennsylvania and Arizona Experimental stations, the officials said, have proven, with tests on rats, that mineral oil offsets the vitamin A benefits from green salads, butter and cream. Other studies have proven that taking mineral oil greatly decreases the efficiency of cod liver oil in supplying the body with vitamin D. . . . —Brawley News.

#### Interim Report of Pepper Subcommittee on Wartime Health and Education

The American Medical Association announces reprints are now available of the interim report of the Pepper Subcommittee on Wartime Health and Education which was published in the *J.A.M.A.* for January 6. An official copy of that report has been sent from the headquarters office of the A.M.A. to the secretaries, presidents, and chairmen of legislative committees of state medical associations, to officers of the American Medical Association, to members of the House of Delegates of the Association, to members of the Council on Medical Service and Public Relations and to certain others.

#### Dingell Social Security Bill: H.R. 395

Representative Dingell, of Michigan has introduced in the new Congress H. R. 395, proposing a broad revision of the Social Security Act, including a compulsory system of sickness insurance. The medical provisions of this bill are identical with those contained in the Wagner-Murray-Dingell bill that was introduced in the Seventy-eighth Congress. Up to February 1, neither Senator Wagner nor Senator Murray has introduced a companion bill in the Senate. It is understood, however, that Senator Wagner has been working on the draft of a new bill, or drafts of new bills, which he intends to introduce in the near future.

#### Doctor Kirk, Surgeon General of Army, Sees No Drop in Casualties

Major General Norman T. Kirk, Surgeon General of the Army, recently said there was little chance that the casualty evacuation rate of 30,000 to 32,000 men a month from combat theaters would decrease as long as fighting continues.

The men brought back to the United States for hospitalization are only 30 to 40 per cent of the total number wounded, said General Kirk, who visited Letterman General Hospital during an inspection tour.

The 60 to 70 per cent of the wounded are treated and made fit for further combat duties at the theater general hospitals and are returned to their units without a trip to the United States.

The flood of wounded has increased to such a degree that the Medical Corps has been forced to abandon its plans to place the men in general hospitals near their homes, General Kirk revealed.

Letterman General Hospital, at the Presidio of San Francisco, has also changed its wartime rôle. Now it is the receiving station for overseas casualties from the Pacific who are cared for at Letterman only until they may be routed to the hospital inland where they will receive full care.

"Letterman and its staff is doing a grand job," said General Kirk. The hospital is commanded by Brigadier General Charles C. Hillman. General Kirk served as chief of surgery at Letterman from 1936 to 1940.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, Esq.  
San Francisco

### Malpractice, Res Ipsa Loquitur

The case of *Ybarra vs. Spangard*, 25 A.C. 479, decided December 27, 1944, by the Supreme Court, involved an action for damages for personal injuries alleged to have been inflicted on plaintiff by the defendants during the course of a surgical operation.

The facts, in the words of the court, were:

"On October 28, 1939, plaintiff consulted defendant Dr. A, who diagnosed his ailment as appendicitis, and made arrangements for an appendectomy to be performed by defendant Dr. B at a hospital owned and managed by defendant Dr. C. Plaintiff entered the hospital, was given a hypodermic injection, slept, and later was awakened by Doctors A and B and wheeled into the operating room by a nurse whom he believed to be defendant D, an employee of Dr. C. Defendant Dr. E, the anesthetist, also an employee of Dr. C, adjusted plaintiff for the operation, pulling his body to the head of the operating table and, according to plaintiff's testimony, laying him back against two hard objects at the top of his shoulders, about an inch below his neck. Dr. E then administered the anesthetic and plaintiff lost consciousness. When he awoke early the following morning he was in his hospital room attended by defendant F, the special nurse, and another nurse who was not made a defendant.

"Plaintiff testified that prior to the operation he had never had any pain in, or injury to, his right arm or shoulder but that when he awakened he felt a sharp pain about half way between the neck and the point of the right shoulder. He complained to the nurse, and then to Dr. A, who gave him diathermy treatments while he remained in the hospital. The pain did not cease, but spread down to the lower part of his arm, and after his release from the hospital the condition grew worse. He was unable to rotate or lift his arm, and developed paralysis and atrophy of the muscles around the shoulder. He received further treatments from Dr. A until March, 1940, and then returned to work, wearing his arm in a splint on the advice of Dr. B."

Plaintiff consulted two other physicians who apparently testified on the trial of the action to the effect that plaintiff suffered from an area of diminished sensation in the region of the shoulder and wasting away of the muscles.

The trial court granted a non-suit rendering judgment in favor of the defendants upon the theory that there was no showing which of the defendants were negligent, that the injury re-

sulted from the act of any particular defendant or that the defendants had control of all of the instrumentalities which might have caused the injury.

The Supreme Court reversed this decision, holding that the familiar doctrine of *res ipsa loquitur* applied, the plaintiff thereby being relieved of the burden of proving how his injuries occurred or that they resulted from the negligence of any specific defendant.

The court stated that where the following three conditions were present, this doctrine requiring the defendants to explain the circumstances under which the injury occurred applies, that is, "(1) the accident must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff."

The court stated that in a modern hospital the patient was quite likely to come under the care of a number of persons and that from the very nature of things a patient could not know all that occurred while he was under the effects of an anesthetic. Here an injury had resulted to plaintiff which had no connection with the surgical operation for which he entered the hospital. The court concluded:

"We merely hold that where a plaintiff receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct."

## LETTERS†

### Concerning Proposed Letter on California Sickness Insurance Laws. From an Over-seas Military Colleague:

Northern France,  
7 February, 1945.

Members of Medical and Nursing Professions, Addressed.  
Dear Sirs:

It has come to the attention of this organization, ———, an affiliated medical unit, now participating in a major way in the support of one of our armies on a portion of the battlefield of France, that the California Legislature is at present in the process of legislating a fundamental change in the practice of medicine. Our being so far away and legally and honor-bound to our Government on a mission so vital, not alone to ourselves over here, but to everyone of you at home, makes our position helpless in personally conveying to you our impressions on a subject so filled with possibilities, both good and bad. Therefore we substitute this letter, our only means of conveying our sentiments, and trust you will vouchsafe it a hearing with the full and fair appre-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

ciation that only an imperfect minimal discussion is, by this means, possible.

It seems superfluous to historically sketch the progress of medicine and surgery during the wartime and peace-life of America; even the advances in the interval from World War I and II are phenomenal . . . the salvage of war's casualties in the present inferno statistically show that. America, today, leads the world in medical science and it has come about through a form of government that has "given the horse the bit" and permitted that free and unrestricted rugged individualism so inherent, and necessary, in the nurse and doctor.

In the hospital evacuation organization with which the writer is connected, are those who were born and reared in the time of, and associated with, the pioneer doctor and are thoroughly conversant with his period; there are a number who have experienced contract practice with both large and small organizations; others in the general practice of medicine; a number with a restricted specialty, and for two and a half years we have experienced governmental medicine. A cross section of the past experiences of our personnel gives a knowledge of the public and personal efficiency under the several systems, for no matter what the change might be, if made, it is interrelated to one or other of the above classification.

To qualify as a physician requires ten years of arduous and intensive work, with a cost of between \$10,000.00 to \$15,000.00. Not uncommonly, more generally than imagined, a goodly part or all of this is owing, when the young doctor begins his career; and ultimately, finally, if successful, he looks forward to a probable maximum, under the present contemplated medical legislative changes, of \$5,000.00 per annum. Such a system, be it State or Federal medicine, is not a procreator of good medicine, for obvious reasons:

It becomes a political football where "whom you know" replaces "what you know"; wherein, comparable to the farmer situation, the middle man "eats" up the percentage and ever and anon the "have nots" are after the "haves"; where the incomprehensible human-behaved people—the belligerent, the queer, the "jittery," the excitable, the depressed, the emotional and all the other variations of the non-pathologic and pathologic states (one of our deep problems here); where those with anything from minor head colds to corns; those of the age when a two weeks' rest in the hospital is preferable and more invigorating than travel, plus its cost, et cetera, et cetera, will clamor for and demand and receive hospital care. To provide for this type, and the *really* sick, will call for millions to be expended for added hospital facilities. It is not the high cost of medicine, rather it is the high cost of hospitalization . . . unfortunately both are added together.

In the last war, Prohibition, with all its divergent ills, was idealistically brought forward. Now comes State Medicine; Federal Medicine really, for there is no doubt California is being used as a guinea pig. What then? It is the entering wedge to sweeping social and economic changes of State and National scope.

Some months ago a questionnaire was sent to each medical man in the Armed Forces. This, questionnaire made no mention of State Medicine but the question was asked: "Would you be interested in some form of group practice?" Group practice to a medical man means something entirely different from State Medicine but we are informed that on the basis of the answer to this question it is claimed that 53 per cent of the medical men in the Armed Forces are in favor of State Medicine. We feel this is a deliberate misrepresentation of the facts. This issue should stand or fall on its merits. The very fact that political trickery of this kind is used to put their proposition over is good evidence that political trickery would be used in its administration if it were adopted.

We in the army are a part of our American government . . . and yet we are not; by necessity we are restricted through Army Regulations—we must, and again we say, by necessity, work as a unit. Individualism and individualistic thinking cannot be, irrespective of what the general public might think. Does California contemplate a continuance of this creed? If so, rugged individualism is deadlier than Dante's Inferno. If this is to be true we suggest the magnificent, trite and ostentatious dictum: "Give me men to match my mountains" be effaced from our California state building, for it would be out of place.

No part of any subject under discussion is unilateral. Medicine has its ills, both organically and individually. We have our weak links . . . but so does every other chain; so long as human nature is human that will be true. We are accused of supporting a Medical Trust. Nothing is further from the truth; the very individualism of its membership prevents such, but we can readily understand how through legislative submersion it might readily be coined. There are many, many members not in accord with either our state or national organization; in like manner there are many many workmen within the crafts not in accord with their leadership . . . such is Democracy.

We have tried, are continuing to try (with some success we feel) and will keep on trying to give the sick, no matter what their station in life or whether their purse is full or empty, that same good care. If there are "gaps" in the care of our citizenry, and we are told there are, and if there are certain groups wherein the cost of medicine (again we feel it to be the cost of hospitalization and not of medicine) is a hardship, it would not appear difficult to adjust such weaknesses by collaboration, one with the other.

The doctor does more than his share of charitable work and through the ages has shown his humanitarian instincts. To revolutionize medicine, is not, seemingly, a sane and sensible approach.

But if our legislative forum feels socialization of medicine, in the manner it is proposed to them, is correct—that that approach is sane, sensible and the only access to the proper protection of the health of our people they have an obligation superior to any appeal we might produce. However, if the procedure is the correct one for the one profession, why should it not be true for all?; the purport to the basic principle is the same. If we can be convinced the point is well taken then we are duty, and morally, bound to make the program a general one.

We are, Sir, in anticipation,

Very truly yours,  
(SIGNATURE OF AN OVER-SEAS COLLEAGUE.)

#### San Francisco Hospital Policy

San Francisco's system of emergency hospitals will not be closed during this wartime period of a shortage in hospital beds, Chief Administrative Officer Thomas A. Brooks said recently.

He added further that he expects no recommendation to close them to come from two public health doctors now surveying the city's health department.

Dr. J. C. Geiger, city health director, said demands have been made upon him for an expansion of the emergency hospital system. Both the Richmond and Bayview districts seek such hospitals, he said.

The survey, expected to be completed in three weeks by Drs. Carl Buck and George Palmer, was undertaken to determine if the city is utilizing its public health facilities in the best manner. It was not intended as a criticism of Dr. Geiger, and is expected to praise his administration.—San Francisco Examiner.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 3, March, 1920

#### EXCERPTS FROM EDITORIAL NOTES

**State Society.**—At the last meeting of the Council, held January 24th, 1920, among other matters of a routine nature, the forthcoming annual meeting of the Medical Society of the State of California was discussed at length. . . .

**An Appreciation.**—Years pass swiftly; fleeting events come and go. The problems of yesterday are forgot in the exigencies of today. With the passing of the problem, we are liable to forget the man behind it. . . .

The Medical Society of the State of California (California Medical Association) has been built up by the hard labor of successive champions in the cause of better medicine. These men and women have had idealism; they have been activated by steadfast purpose and have spent their life's energy in our behalf. Where others were indifferent and neutral, these leaders forged ahead and bid us follow. They led the fight against disease, ignorance and vice. They wrought the machinery for preventive medicine. They educated and coerced the public into better sanitation and personal hygiene. They built up the laws and ordinances which make for higher medical standards and eliminate quackery. We reap the benefit of their pioneer industry. We saw them at work; possibly, we differed with them over methods and means of achievement; mayhap, we scoffed at their efforts. Nevertheless, we have been blessed by the fruits of their labor. They were vital; they did not spare themselves. But now the spark has gone and the flame grown dim. We see them pass. In passing let us doff our hats and do them homage.

You who have served—you have given what cannot be lost. For the good you have done, we now offer you our gratitude.

You are among the Immortals.

**Nurses Needed.**—"What are we going to do to get more nurses?" This question has been asked of the JOURNAL in written and various verbal forms so often, that we decided to place the question before all our readers instead of continuing to answer it privately and piecemeal.

That there is a shortage of trained nurses, and nurses in training, is generally felt. The medical profession is the first to feel this need and appreciate its seriousness, but it is a matter of concern to every hospital and to every citizen and family of every community. . . .

**Botulism.**—Botulism has been recorded more frequently in California probably because more constant search has been made for it, although possibly because its incidence may be higher on the Pacific Coast.

Not only is botulism a form of meat poisoning, but it has arisen from the use of home canned products, both vegetables and fruits, in various parts of the country. . . .

(Continued in Front Advertising Section, on Page 17)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.

Secretary-Treasurer

### Board Proceedings

Dr. Richard O. Bullis of Los Angeles was appointed by Governor Warren, vice Karl C. Gummess, whose term expired on January 15, 1945. Dr. Frederick N. Scatena of Sacramento was reappointed by Governor Warren, his previous term having expired on January 15, 1945.

An oral examination will be held in the Board office, 515 Van Ness Ave., San Francisco, on May 20, 1945. The examinees at oral examinations comprise doctors from other states applying on licenses issued more than ten years ago. Also certain Army and Navy doctors are required to take the oral examination and certain other physicians must also pass this examination.

An additional written examination has been scheduled to be held at Native Sons Hall, 414 Mason St., San Francisco, May 21, 22 and 23, 1945. This examination was scheduled to accommodate many applicants located in the northern part of the State, who expect to enter military service on June 1st. Applications for this examination should be received at least two weeks prior thereto.

### News

"In view of the urgent need for trained physical therapists and at the request of the War Department, the Children's Hospital Society and Clinic, located at 4614 Sunset Boulevard, announced today it would begin a six-months emergency course of study, beginning February 5. At the present time there is a great need for trained therapists in army, navy and civilian hospitals, Lily H. Graham, technical director of the hospital declared, adding that, to remedy this shortage, the course of study in therapy will be open to women only who have passed their thirty-seventh birthday and who are either registered nurses or have had at least 60 semester hours of college." (Los Angeles Herald and Express, January 2, 1945.)

(Press dispatch dated Sacramento, January 24, 1945.) "Backed by prominent Californians, a broad legislative program designed to give adequate education and medical treatment to an estimated 10,000 children in the State crippled by cerebral palsy was presented to the State Legislature today. Key features of several bills going into both houses of the Legislature are provisions to establish two hospital schools, one in Southern California and the other in Northern California. They would be operated by the University of California and the State Department of Education. It is estimated each school would cost \$200,000 to build. The schools will provide both special education and medical treatment, including physiotherapy, for spastic children who have been afflicted with cerebral palsy usually caused by injuries at birth. . . ." (Los Angeles Examiner, January 25, 1945.)

"'Plasma and more doctors—they are what the navy needs to carry on the Jap war in the South Pacific.' That was the declaration made today by Lieut. Comdr. Edwin S. Budge, Jr., Los Angeles ear, nose and throat specialist,

(Continued in Back Advertising Section, on Page 34)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.